DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2004

THURSDAY, MARCH 13, 2003

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:22 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Christopher S. Bond (chairman) presiding.

Present: Senators Bond and Mikulski.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ANTHONY J. PRINCIPI, SECRETARY OF VETERANS AFFAIRS

ACCOMPANIED BY:

ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH

VICE ADMIRAL DANIEL L. COOPER (USN RET.), UNDER SECRETARY FOR BENEFITS

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WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT

RICHARD GRIFFIN, INSPECTOR GENERAL

OPENING STATEMENT OF SENATOR CHRISTOPHER S. BOND

Senator BOND. The subcommittee will come to order. Thank you very much for waiting for us. Senator Mikulski and I had a vote, and she is over here very engaged in preparations, and she suggested I go ahead and begin. We apologize for the delay, but those of you who have dealt with the schedule of the Senate know that Murphy was an optimist in drafting Murphy's Law.

This morning, the VA, HUD, and Independent Agencies Subcommittee will conduct its budget hearing on the fiscal year 2004 budget for the Department of Veterans Affairs. It is a pleasure to welcome back Secretary Tony Principi to our subcommittee, and his colleagues. Mr. Secretary, I am very pleased to have you here today to discuss your Department's fiscal 2004 budget. Before I launch into the budget, I join with my many, many colleagues in expressing our deep gratitude and appreciation for the hard work you and your team are doing and the time you put into responding to the

needs of our Nation's veterans, and for my part most especially, to the needs of some 566,000 veterans in my home State of Missouri.

Mr. Secretary, when you entered office 2 years ago you were faced with some of the most difficult challenges of any Cabinet head. However, I can say unequivocally that you have met those challenges head on with strong leadership, decisiveness, compassion, and persistence.

I congratulate you on the tremendous progress you have made in correcting some of VA's longstanding problems. We are impressed by your accomplishments, and look forward to continuing to work with you in meeting the needs of our Nation's veterans. Nevertheless, VA continues to face some extremely difficult challenges, most notably in the area of providing quality and accessible health care to our Nation's veterans.

Addressing the health care needs of our veterans is even more sensitive to all of us because of the great uncertainties of what perils lie in the seeming inevitability of war against Iraq. It is unfortunate we are in this position, and I know that all of us, including the President, believe that war should only be used as a last resort. History, however, has demonstrated that military force must be used on occasion to preserve the peace and prevent even greater death and destruction.

Nevertheless, our hearts and prayers go out to the 240,000 men and women of our Armed Forces who are currently in the Persian Gulf region and to those forces of the other allied nations. Mr. Secretary, I know you personally know all too well the horrors and tragedies of war, and it is that perspective that I know influences and helps guide your actions in thinking and helping our Nation's veterans.

Last year when you appeared before the committee, we talked a great deal about the growing health care crisis facing VA. Unfortunately, despite significant funding increases and regulatory actions taken by the VA, access to the health care system continues to be a major problem.

Today's problems with the VA health care system can be traced back through the history of the VA. The veterans medical care system was originally created to provide needed care to veterans injured or ill from wartime service, veterans with service-connected disabilities. Over the time, the system has become a safety net for veterans with service-connected disabilities, veterans with specialized service needs, and lower-income veterans. These three groups are the VA's core constituents. VA's first and foremost mission is to assist these veterans.

Up until 1996, VA served its core constituents. However, eligibility reform enacted in 1996 expanded VA medical care services to veterans not previously served. These veterans do not have service-connected disabilities, and have comparably higher incomes than those of VA's core constituents. The Veterans Health Care Eligibility Reform Act of 1996 required VA to create priority categories for enrollment to manage access in relation to available resources. Therefore, a higher priority for enrollment was provided to veterans with service-connected disabilities, lower incomes, or specialized service needs.

These higher priority enrollees are ranked in priority order from 1 through 6. Veterans without service-connected disabilities and with relatively higher incomes are ranked priorities 7 and 8. While the act requires the creation of these priorities, all priorities were provided equal access to health care services. In other words, the act created a first-come, first-served system.

The 1996 act predicted that the new requirements and expansion of services to previously unserved veterans would have no net funding impact to the Federal Government. In other words, it would be budget-neutral, because there would be few new enrollees.

The committee report stated that the view of VA being besieged by a large wave of new enrollees for VA care is unrealistic. In case you missed it, let me restate that statement. The committee report said the view of VA being besieged by a large wave of new enrollees for VA care is unrealistic, close quote.

The report also quotes testimony about Paralyzed Veterans of America. They found VA's best potential market is those who have the most familiarity with the system, that is, those currently using the system, close quote. Even data from the VA's 1995 national survey of veterans indicated a large proportion of veterans would rather go to a non-VA facility for their medical care if given a choice, close quotes. In other words, neither the authors nor the veterans service organization believed that VA would attract new veterans into the system. Amazing. What a bad guess.

In 1999, Congress further expanded health care benefits for veterans by passing the Millennium Health Care Act. This act provides additional benefits such as long-term care and emergency services. Further, Congress encouraged and funded hundreds of new VA community based outpatient clinics to increase access delivery points for veterans living in areas far from in-patient centers. The creation of new CBOC's verified the truth behind the old saying, if you build it, they will come, and they did.

Since 1996, the fastest-growing segment of the VA health care system has been those veterans without service-connected disabilities and with higher incomes. Many of these veterans have other health insurance options compared to VA's core constituents, and they have other health care options, but the view of VA being besieged by a large new wave of enrollees for VA care is not unrealistic, it is a fact. VA now serves 2 million more veterans than it did prior to the implementation of the 1996 act.

Further, VA cannot provide generous health care benefits for all veterans and expect to maintain quality and timely health care service delivery. VA cannot be everything to everybody. The uncontrollable demand of veterans seeking VA health care benefits has resulted in a waiting list of over 200,000 veterans. These veterans have been told that they cannot get an appointment for at least 6 months—6 months. In some cases, veterans have been told to wait 1 to 2 years.

That is unacceptable. We cannot ignore the many medical needs that require immediate attention. Moreover, many of these veterans on the waiting list are VA's core constituents, those with service-connected disabilities, lower income, or with specialized service needs.

Mr. Secretary, I read with great interest about the Gordon Mansfield experiment, when you sent out your Assistant Secretary for Legislative Affairs to eight VA clinics. I was appalled to learn that Mr. Mansfield, who is a service-connected disabled veteran who served with distinction in the Vietnam conflict, was wait-listed at six of those clinics. It is unconscionable that veterans in the position of Mr. Mansfield are in this situation.

In addition, the sad fact is that more veterans like Mr. Mansfield will face this situation if we do not act. The outyear projections of even more non-core patients coming into the VA system are staggering. The convergence of these factors, combined with a lack of a Medicare prescription drug benefit, an aging veteran population, and the greatly improved quality of care provided by VA clinics, created the current dilemma we are facing today. The system is in crisis, a storm that we could call the perfect storm.

Mr. Secretary, you are in the eye of the storm, and to bring our core constituent veterans out of it you made some difficult decisions. Last year, VA began requiring health centers to provide priority access for service-connected veterans rated 50 percent or greater. This past January, the Secretary exercised legislative authority to suspend new enrollments of priority 8 veterans.

The decision to suspend priority 8 enrollments was not popular, but it was consistent with the Eligibility Reform Act of 1996, which provided the authority to suspend enrollments. As the committee report states, the VA may not enroll or otherwise attempt to treat so many patients as to result either in diminishing the quality of care to an unacceptable level or unreasonably delaying the timeliness of VA care delivery.

Mr. Secretary, you did the right thing. It was not popular, but doing something popular is not always right, and doing something right is not always popular. I support your decisions, and you did what the law expected you to do, because we cannot compromise health care quality and access for our core constituents. These men and women rely on VA's health care system. They have nowhere else to go. We cannot and must not leave these men and women behind.

Despite the huge waiting list and the growing demand for VA's health care services, I am optimistic that we can resolve this crisis. You have my personal commitment that I will work with you to solve the crisis fully. The record demonstrates this committee in a bipartisan manner has viewed medical care funding as its top priority and, as chairman, I will continue to keep that as our top priority. It has always been my belief that our goal should be to fund fully the health care needs of the core constituency priorities 1 through 6. The record shows that we have, in fact, accomplished that goal, but we have not achieved the results.

Part of the solution is resolving the crisis in funding. In terms of the fiscal 2004 budget, the President proposed $62.8 billion for VA. It includes $30.1 billion for discretionary programs, and $32.7 billion for mandatory. The discretionary funding request is $2.1 billion, 7.5 percent more than the fiscal year 2003 enacted level.

The most notable item is $25.4 billion for medical care, a $1.5 billion increase over fiscal year 2003. We increased the 2003 medical care budget by more than $2.5 billion over 2002. These funding

increases are not only a cry of need, but a cry for help. I regard the budget request for medical care as a floor, but there is a ceiling due to our other compelling needs such as affordable housing, environmental protection, scientific research, and the Space Shuttle and its safety.

Further, it is clear that the funding level for VA medical care cannot be sustained without reform of the system. Nevertheless, under any budget climate this is a good budget. This is the largest dollar increase ever submitted by any administration, and would provide VA almost $9 billion more funds for medical care than provided in fiscal 1996.

The request also contains a number of policy initiatives to refocus health care on the core constituents. I think they are worthy of further discussion. They appear to be reasonable, and I think the $250 annual enrollment fee, an increase in co-pays deserve a fair and full examination.

It also provides in the budget a down payment of $225 million for the CARES program, which is a positive step, and I fully support CARES, because we cannot pour resources into half-empty hospitals or exist primarily to serve research and financial interests of medical schools. VA's first and foremost mission is to care for our Nation's veterans. CARES is an integral part of assuring that we focus on that and align our expenditures to those needs.

I am committed to funding the health care needs, but it is more than a funding matter. There is much more to be done in the management area, and greater accountability in performance and consistency are required throughout the VHA. Third party collections of the VHA are projected to collect $524 million this year compared to last year at a time when the GA has found that VA has improved collections, but suggests that VA could have collected hundreds of millions more.

The VAIG report estimated that it could have collected $500 million more. Due to the operational limitations of VA, however, VA lacks a reliable estimate of uncollected dollars and therefore does not have the ability to assess the operational effectiveness.

Collections continue to be a problem, but one of the most infuriating problems I have seen recently is the time and attendance controls for VA-paid part-time physicians. The Inspector General audit of the Lexington, Kentucky Veterans Affairs Medical Center found that VA was paying for part-time physicians who are not actually treating veterans. They were from medical schools, performing research or other duties outside VA.

The IG said that some time and attendance cards were falsified. These actions resulted in $1.15 million in annual salary costs for physicians not performing their duties at the VA hospital. That jeopardizes patient safety. Ward nurses did not have the resources to deal with matters like patient restraint and medication changes. This is appalling and unacceptable, and I will follow up with some questions for Dr. Roswell on this.

The last point I should touch on is a variance in the network. Veterans from Missouri and across the Nation have told me about the wide performance variance among the 21 divisions. Some veterans have complained that specialized services have gotten the short end of the stick. I supported Dr. Kaiser's reorganization of

VHA, but I believe it has gone too far, and we cannot afford to have the networks operated as 21 fiefdoms. Veterans in Missouri are very, very pleased to have such good service but why should a veteran in Missouri receive better care than a veteran in Kansas? I think it is time to review the structure of the 21 networks.

Finally, Mr. Secretary, let me restate my appreciation for your hard work and the great leadership you provided. Your work on improving claims processing has been outstanding. I commend you on your efforts for CARES. I am gratified by your visits to Missouri, and responsiveness in addressing some horrible sanitary problems at the Kansas City VA Medical Center after they have been ignored for years. I look forward to our continued working relationship in addressing the needs, and I will turn now to my colleague, Senator Mikulski, for her statement.

STATEMENT OF SENATOR BARBARA A. MIKULSKI

Senator MIKULSKI. Good morning, Mr. Secretary, and to all the people of the VA team. Mr. Secretary, we want to thank you for visiting the Baltimore VA medical facility earlier this week, and bringing Secretary Thompson to the VA in Baltimore to show how we have been using technology to provide more efficient care in acute care, and to be able to provide better care when that patient returns to the primary care situation.

I thought it was fascinating that it showed that the best way to provide technology for patient care was not to treat it as a billing system, as we were advised, but to treat it as a patient management system. You can bill off of it, but you cannot manage patients off of a billing system, but you can bill off of a management system.

I thought it was great that Tom Scully was there. He was there, because the issues that we are seeing in VA and that are grappled with not only in Baltimore but throughout the VA system are models for what we need to do in private sector care, so we were honored to have you, and I know the staff appreciated your coming and I know you, like I, were very proud of what they are doing there.

And I think Secretary Thompson got an eyeful and his staff got an earful, because he kept saying, why can we not do that, why can we not do that now?

We are glad that the VA is a model.

We know that the VA medical system is under a tremendous stress, with the passing of the World War II generation and their very unique and often multiple needs, the coming ever-increasing numbers of the Korean War veterans, as well as the Vietnam veterans, so just in terms of the sheer population, we know that VA faces a number of challenges, and we also know that VA will be a significant back-up as we go to war, to be able to deal with the possibility of significant casualties, and we also know that the VA medical system stands in support of our war against terrorism, where our major metropolitan areas could face mass casualties.

But as we look at the VA budget, first of all we appreciate the President's increase in veterans' medical care. We also appreciate the fact that you are focusing on those four areas, and we want to work with you. You are a Vietnam vet. You have served your country in war, and you continue to serve it as the Secretary of VA, but when I looked at the VA budget, I had two things in mind. First,

we have got to keep the promises, keep the promises we made to our veterans, and second, that the budget needs to make highest and best use of taxpayers' dollars so that both the Veterans' Administration and the veterans themselves get a bang for the buck.

What I am concerned about, though, is that in this year's budget we place toll charges on veterans. This means there is now an entrance fee to get VA medical care if you are category 7 or if you have been grandfathered into category 8, and also that there will be higher co-pays.

I am also concerned that there are now waiting lines to get medical care, waiting lines for medical care. I have had a longstanding work—going back when you worked for President Bush's dad as Deputy, we have been concerned about the claims-processing time, and to me, if you are a veteran and you are coming for medical care, there should be no waiting lines, and as we understand it there are almost one-quarter million veterans who now have a waiting time issue, and we want to talk with you about that. I am concerned that the budget OMB gave VA does not really help you, or help you address those needs.

When we look at the priority 8 veterans and even the priority 7 veterans, we see that from both the IG's report and the GAO report, and I believe your own analysis that we discussed with you last year, they are primarily coming to VA because of a prescription drug benefit, not only because of the changes in the law, as Senator Bond has articulated, but they are coming for a prescription drug benefit.

I note that the GAO report says that we spent $418 million on outpatient pharmacy benefits for priority 7 last year, and that priority 7 use of pharmacy benefits have increased rapidly. Also, they say for those in categories 1 through 6, they have increased, but given the nature of their wounds and their age, we would expect that, but it would seem to me that the category 7s, based on GAO reports—and I can go over the figures. You know the figures.

Well, we went from 107,000 veterans to 827,000 veterans. That is the budget-buster, but the question is, why are they coming? Well, first of all, there is good care, but I also believe they are coming because of the failure in public policy. I believe they are coming because there is no reliable prescription drug benefit that many of them have access to in the private sector.

When you look at the Inspector General's report, you also see that veterans in those categories are coming not only for a prescription drug benefit, but in many instances they have been written by their own physician, but they are coming to you to be their drugstore because of the prescription drug benefit. These are real challenges, and I want to discuss them, and I believe that the way that you are trying to meet them is by the $250 entrance fee, and also the increase in copayments.

Now, I want to get why you think that is going to work, is that the way to do it, do we need a prescription drug benefit that really addresses those needs, because I believe it is going to be worse. I believe that many of the veterans who are coming are either people—primarily men, though some women—who work, who have no health insurance. They are either self-employed or they work in small business. They might have names like Hank or Buck, and

they work in home improvement and so on. They need you. You are the safety net for them.

But I also know that with the downturn in manufacturing, the collapse of 300,000 jobs in our economy, where many had worked for companies, whether it is steel industries, like Pennsylvania, and my home State of Maryland, Beth Steel, the airline industry, the collapse of those industries that normally had a defined benefit plan and the collapse of their health insurance means that they are diverting themselves to VA.

I do not fault them. This, I believe, is a matter of fact. This is not a matter of fault, but we are either going to have to have a national policy to address those needs, or it is going to continue to fall on VA, and you are going to continually invent mechanisms that put you in a prickly position with veterans, and we have got to get at how to deal with this, and I wonder if you agree with my analysis when we do this.

I could go on, but I feel that this is one of the number one challenges, the lack of health insurance for many, and then a lack of prescription drug benefit for even more as the population gets older.

Now, I am really proud of what you are doing in medical research, and I am proud of our research community. People are alive longer and live better because of the research that is being done both by VA to help the veterans that then moves into the common medical practices, but as a result, people are living longer with chronic conditions. Those chronic conditions are managed by prescription drugs, access to primary care, and then ancillary services like physical therapy and chiropractic and other care.

So we have got to get a handle not only on the budget, but recognize the needs of the population and see why they are coming. We could keep building it, and they are going to keep coming, and then that will take us to how we are going to deal with the waiting lists, how we are going to deal with the clients' processing times, and how we are going to work on those issues, so these are not only budget issues and appropriations issues, I believe they are some of the most significant challenges.

Now, just as the VA has led the way in technology, and I have seen it in my own home town—Senator Bond, you would be pleased, the technology that we did there for patient management has made the use of physicians' and nurses' time more efficient, reduced medical errors, and actually improved patient outcomes, and we had the data to show it, but we did not go for some big megasystem where we ended up with a boondoggle. We ended up with a patient management system that has improved management. Just as we are the leader in that area, I think we now have to be a leader in how we are going to deal with prescription drugs.

So there are many other issues on research and others that I would like to raise.

The other thing is, I am glad you are taking up the cemetery issue. The World War II generation is passing on. We need to retire them with honors. Yesterday, we laid to rest my uncle, Florian Mikulski. He fought at the Battle of the Bulge. He was a Purple Heart guy, he was a Bronze Star guy, so there was an honor guard at the funeral, which meant a lot to our family.

He went to a private Catholic cemetery, but when you look at him he was an ordinary guy. He helped run our fabulous Mikulski's baker's shop. He went off to war. He was a hero, and came back with a steel plate and all the permanent things, went to work, never said another word about it, and we have got to look out for those guys. We have got to look out for them in their medical care, and when they pass on, to do it in a place that has as much dignity as they deserve, so thank you for taking that up, and I look forward to your testimony.

PREPARED STATEMENT

Senator BOND. Thank you very much, Senator Mikulski. Senator Johnson submitted a statement which he would like to have included in the record.

[The statement follows:]

PREPARED STATEMENT OF SENATOR TIM JOHNSON

Mr. Chairman, I thank you and Ranking Member Mikulski for calling today's hearing to talk about the fiscal year 2004 budget for the Veterans Administration (VA). Your commitment to caring for our nation's veterans and your leadership on this Subcommittee is greatly appreciated by me and the veterans of South Dakota.

I would also like to thank Secretary Principi for appearing before the Subcommittee. You have a very difficult job and I thank you for your continued willingness to serve our nation.

At a time in which we are asking so much of the men and women serving in our Armed Forces, I believe it is essential that we send a clear signal of our commitment to care for our military personnel both on active duty and as veterans. For decades, the men and women who joined the military were promised educational benefits and lifetime health care for themselves and their families. Those promises have too often not been kept.

Mr. Chairman, several weeks ago I had the opportunity to visit VA facilities in South Dakota. This gave me the chance to meet with veterans and to listen to their thoughts. By far, the issue of greatest concern to them is health care. These veterans rely on the VA for their health care, they see a continued erosion in their benefits, and they are deeply troubled about the long-term viability of the VA health system. They want assurances that they will be able to access quality care in the future.

Unfortunately, years of inadequate funding for VA health care have pushed the system to the brink of crisis. I am concerned that the quality of care is starting to suffer. Let me be clear, this has nothing to do with the men and women who work in the VA health care system. They are dedicated professionals who care about the veterans they serve, but they are being asked to do too much with too few resources.

Instead, I believe the problems in the VA health care system stem for the administration's failure to ask for adequate funding. While the number of veterans in the United States has decreased over the years, the number of veterans utilizing the VA health care system has increased exponentially. This is due in large part to the availability of Community-Based Outpatient Clinics and the prescription drug benefits available through the VA. According to the VA, the number of veterans enrolled in the health care system has increased from 3.8 million in 1996 to 6.8 million in 2002.

While the VA has become the health care system of choice for many veterans, the system is simply not equipped to handle this kind of patient influx at the current funding level. The strain on the system is evident in that the VA estimates over 200,000 veterans are waiting for appointments—half of them will end up waiting six months or more. In Sioux Falls, a veteran can wait up to twelve months to get an appointment at the VA.

The VA tells us these problems stem from having to operate with "limited resources." Based on this explanation, one would think Congress has been providing the VA with less funding than requested by the President. Nothing could be further from the truth. In fact, the VA-HUD Appropriations Subcommittee, under the leadership of Senators Mikulski and Bond, has provided funding for veterans health care in excess of the VA's request for the past several years.

In fiscal year 2001, Congress provided a $1.4 billion increase in veterans health care funding over the Administration's initial request. In fiscal year 2002, we succeeded in adding $1.1 billion during consideration of the VA-HUD Appropriations bill. In addition, as a part of the fiscal year 2002 Emergency Supplemental Appropriations bill, Congress included another $417 million for veterans health care. Even though Secretary Principi argued the VA needed all of this additional funding, the President refused to spend $275 million that was earmarked for veterans medical care.

In fiscal year 2003, the President requested just $22.7 billion for the VA health system, far less than what was needed. Congress, once again, was forced to step in and appropriate an additional $1.2 billion.

Mr. Chairman, this pattern of the President underestimating the VA's needs and then relying on Congress to make up the difference is simply unsustainable over the long-term. And as I look at the President's request for fiscal year 2004, I fear we find ourselves once again in the same situation. The good news is the President has requested an additional $1.3 billion in appropriated funds for VA health care over what Congress provided in fiscal year 2003. This is a step in the right direction.

However, the bad news is this is still not enough money to fund the needs of the VA health system. According to the Independent Budget—an independent analysis of the VA budget prepared by AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars—the President's request shortchanges the VA by about $2 billion. The failure to provide sufficient funding will have real consequences for veterans. It will mean veterans will continue to have to wait up to twelve months to get an appointment, it will mean the VA will not be able to hire additional health care professionals, and it will mean there will be a further decline in the quality of care provided for our veterans.

Rather than addressing the problem and providing the needed funding, the President apparently has decided his solution is to turn veterans away from the system. The President's budget includes a proposal to carry-out the VA's recent decision to deny enrollment of future Category 8 veterans, which will leave at least 360,000 veterans without access to care. In addition, he is seeking authority for a $250 enrollment fee for certain veterans. According to the VA's own estimation, this will force 1.3 million veterans to leave the system. Finally, the President has proposed significant increases in co-payments for pharmacy and primary care benefits, thus shifting an even larger financial burden to our veterans.

Rather than contracting and restricting VA medical care, I believe we need to look for ways to improve access and quality of care so that we can fulfill our past promises to our veterans.

Mr. Chairman, for me, fully funding the VA is a national security issue. Veterans are our most effective recruiters. However, inadequate benefits and poor health care options make it difficult for these men and women to encourage the younger generation to serve in today's voluntary military. Although we once again face difficult budgetary decisions, the only question is whether veterans health care should be a priority or an afterthought.

Every time I have the opportunity to meet with veterans, I am reminded of the tremendous sacrifices they have made on behalf of our country. We owe each of them a debt of gratitude that can never be fully repaid. One of the things we can—and must—do for our veterans is to honor the promises we have made to them. This starts with providing those veterans with access to the quality health care they deserve.

As we begin consideration of the fiscal year 2004 VA-HUD Appropriations bill, I look forward to working with my colleagues on the Subcommittee to ensure full funding for the VA.

Once again, I thank Secretary Principi for taking the time to appear before the Subcommittee this morning. I look forward to hearing your thoughts on the many issues of importance to South Dakota's veterans.

Senator BOND. Now, Mr. Secretary, if you would proceed, please.

FISCAL YEAR 2004 BUDGET REQUEST SUMMARY

Secretary PRINCIPI. Thank you very, very much, Mr. Chairman, Senator Mikulski. Of course, I thank you for the opportunity to present and discuss our proposed budget for fiscal year 2004, but perhaps more importantly, I thank you for your tremendous support for my Department and the people we serve. I believe the budget we have this year is eloquent testimony to that support,

and I assure you we will do everything in our power to achieve the goals that we share and use that money wisely.

Our budget sets forth clear priorities. However, priorities necessarily call for choices, and where difficult choices are necessary, our budget identifies and acknowledges them and, as you have both so eloquently stated, we do have enormous challenges that lie ahead, but I am confident that by working together we can get there.

This is a good budget in absolute terms, in percentage terms, and in comparative terms. In absolute terms, the President requests a total of $63.6 billion, $33.4 billion for entitlement programs and $30.2 billion for discretionary spending. In comparative terms, the President is asking for a greater percentage increase for VA than for any other Department of Government, and in percentage terms, this represents an increase of 7.7 percent over this year, and a 21.4 percent increase over the past 2 years. I am proud of the work of our leadership team who are here with me today and their efforts with OMB in fashioning and helping us get this budget to present to you.

The budget the President submitted to Congress will fund the Veterans Benefits Administration's—Admiral Dan Cooper, our Under Secretary is with us—continued progress towards achieving my goal of benefits decisions in 100 days with no more than 250,000 cases in our working inventory.

This budget also funds the activation of four new national cemeteries—Acting Under Secretary Benson is with us—advanced planning on a fifth for activation in 2005, and will allow us to make continued progress toward our commitment to maintain our cemeteries as national shrines.

For health care—Dr. Roswell, our Under Secretary is to my left—the program that dominates our discretionary budget—the President asks the Congress to commit an additional $2.1 billion to treat veterans' illnesses and disabilities. Approximately $500 million will come from increased collections or copayments, and $1.5 billion, as you indicated, will come from increased appropriations of taxpayers' dollars.

In addition, the budget directs VA to identify approximately $950 million through management efficiencies. I am acutely aware that every dollar unnecessarily expended is a dollar unavailable to provide health care to sick veterans. I know that $950 million is a lot of money, and it sounds like a lot of money, but I would point out that in this country in 2002 the annual increase in productivity across the Nation in the business sector, business productivity, manufacturing productivity has increased by 4.7 percent, and this increased efficiency of $950 million represents only 3.4 percent, so I think it is achievable. It is aggressive, but I believe we can do it.

I established a Business Oversight Board, directed construction of information technology enterprise architecture, chartered a procurement reform task force, and placed a high priority on improving our collection of copayments and insurance payments, an issue that has been of great concern to you and to this committee. Our progress leaves me comfortable with an aggressive but achievable goal for management efficiencies.

I will not hide from the fact that this budget assumes that VA will sharpen its focus of our care on those veterans identified by Congress as having the highest priority, our service-disabled, those who have few options for health care in this country, as some of the issues that Senator Mikulski highlighted in her statement, the lower-income people, and those who need our specialized programs, such as spinal cord injury, mental health, blind rehabilitation.

We project that we will treat 167,000 more of these veterans in 2004, but as you well know, our projections have not been very accurate for the very reasons, again highlighted by you, that we have an open enrollment policy with the exception of category 8, and changes in the economy, no prescription drug benefit, has caused more and more veterans to come to us seeking care.

Last year, we enrolled almost 900,000 new veterans in the VA health care system. We have grown from about 2.9 million enrolled in 1998 to 6.8 million enrolled today. Overall, we enrolled almost 200,000 more than we expected, 70,000 more users than we expected last year, again for some of the reasons that you highlighted that they are coming to us, and it has clearly stretched our system to the breaking point.

There is no question that we face enormous challenges in providing care with a fixed budget for this ever-increasing number of veterans who come to us for treatment and pharmaceuticals. When demand for care exceeds our capacity, veterans have to wait longer for that care. On behalf of those veterans and the VA health care professionals who will treat them, I thank you for the $2.5 billion increase that you gave us this year.

Those funds, combined with management actions I have directed, should allow us—and I made it a very high priority—to eliminate this backlog of veterans waiting for care, waiting more than 30 days to see a primary care physician, by the end of this fiscal year. All of our energies and those of my Under Secretary for Health and all of our people around the country are focused on using that $2.5 billion to increase our treatment capability to bring that backlog down.

WAITING LISTS

I would note that most of the veterans who were on last year's waiting lists have now been seen, only to be replaced by additional veterans who have sought care since then. The existence of waiting lists illustrates the tension between fixed resources and potentially unlimited demand for care. The Congress clearly anticipated this tension when it both enacted the statutory requirement for me to make an annual enrollment decision and designated priority groups for constraining enrollment when necessary, priority groups 1 through 8.

Last year's waiting lists were symptoms of an imbalance and, as I am required to do, I took action to bring veterans health care back into balance. I directed the VHA to continue informing veterans about their benefits, to be part of the community but to cease actively recruiting new patients until we can get a handle on this backlog.

I suspended enrollment of additional higher-income priority 8 nonservice-connected veterans and, as part of the budget before you

today, I proposed policy to strengthen VA's focus on veterans in the higher-priority groups established by Congress, eliminated the copayments for the poorest of the poor.

Currently, we collect copayments from any veteran who has an income of $9,000 or more. I proposed to eliminate the copayment for any veteran who has an income of $16,000 or less, but I have also proposed, for those who can most afford to share a little of the cost of their care and who have other options, to have a slightly increased copayment and to make an annual enrollment fee premium of $250, which is very consistent with the military's TRICARE Prime program, where any military retiree who is entitled to health care must make an annual enrollment payment.

SUSPENSION OF PRIORITY 8 ENROLLMENT

I acknowledge that my recent decision to suspend additional enrollment of veterans in the priority 8 group has put us on a course through uncharted waters, and I will monitor our outcomes. I will monitor our growth in workload very carefully to ensure that we do not overshoot the mark, because I want to make sure that we see as many veterans as possible who seek care from the VA as long as we can do it in a timely and quality manner, and I will not hesitate to act to right the course, to reopen enrollment if I believe we can care for veterans in priority group 8. However, failure to address a continuing imbalance would inevitably result in longer waiting lists, poorer quality of care, and perhaps even actual disenrollment of priority 8 veterans, a decision that I would be loath to make.

I have to emphasize that the tension between resources and demand for care is not a 1-year issue. A decision to reject demand management initiatives this year would only compound the problem for us in future years, because veterans who are enrolled today may not seek to use the health care system today, but next year or the year after, so the costs grow exponentially as veterans become older and sicker.

My enrollment decision does not mean that VA believes higher-income veterans are unimportant. They are very, very important. We are working with HHS, and I am so pleased that Secretary Thompson and I visited Baltimore to begin to break down the barriers and the walls that have all too often existed in this city between agencies of Government who have similar missions. In health care, it is VA, it is HHS, and DOD.

PREPARED STATEMENT

Oftentimes we get caught up on turf and jurisdiction, and we do not see the benefits of working together collaboratively to provide the health care that veterans, that military retirees and that Medicare-eligible citizens receive, and I think that by working together across the spectrum of health care, in research, in prescription benefits, and in health care in general, I think we can do a lot more by working together, and I think this visit demonstrated a willingness on Secretary Thompson's part for doing that. I thank you, Senator Mikulski, for joining with us on that important visit.

Mr. Chairman, Senator Mikulski, and really all the members of the committee who cannot be here today, I appreciate your advo-

cacy and support for veterans, and we are prepared to answer your questions.

[The statement follows:]

PREPARED STATEMENT OF THE HONORABLE ANTHONY J. PRINCIPI

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2004 budget proposal for the Department of Veterans Affairs (VA). The centerpiece of this budget is our strategy to bring balance back to our health care system priorities. I have by my decisions and by my actions focused VA health care on veterans in the highest statutory priority groups—the service-connected, the lower income, and those veterans who need our specialized services. This budget reflects those priorities.

The President's 2004 budget request totals $63.6 billion—$33.4 billion for entitlement programs and $30.2 billion for discretionary programs. This represents an increase of $3.3 billion, which includes a 7.7 percent rise in discretionary funding, over the enacted level for 2003, and supports my three highest priorities:

—sharpen the focus of our health care system to achieve primary care access standards that complement our quality standards;
—meet the timeliness goal in claims processing;
—ensure the burial needs of veterans are met, and maintain national cemeteries as shrines.

Virtually all of the growth in discretionary resources will be devoted to VA's health care system. Including medical care collections, funding for medical programs rises by $2.1 billion. As a key component of our medical care budget, we are requesting $225 million to begin the restructuring of our infrastructure as part of the implementation of the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our 2004 request using a new budget account structure that more readily presents the funding for each of the benefits we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program.

MEDICAL CARE

The President's 2004 budget includes $27.5 billion for medical care, including $2.1 billion in collections, and represents an 8.0 percent increase over the enacted level for 2003. These resources will ensure we can provide health care for over 4.8 million unique patients in 2004.

The primary reason VA exists is to care for service-connected disabled veterans. They have made enormous sacrifices to help preserve freedom, and many continue to live with physical and psychological scars directly resulting from their military service to this Nation. Every action we take must focus first and foremost on their needs. In addition, our primary constituency includes veterans with lower incomes and those who have special health care needs. By sharpening the focus of our health care system on these core groups, we will be positioned to achieve our primary care access standards.

The demand for VA health care has risen dramatically in recent years. From 1996 to 2002, the number of patients to whom we provided health care grew by 54 percent. Among veterans in Priority Groups 7 and 8 alone, the number treated in 2002 was about 11 times greater than it was in 1996. The combined effect of several factors has resulted in this large increase in the demand for VA health care services.

First, the Veterans Health Care Eligibility Reform Act of 1996 and the Veterans Millennium Health Care Act of 1999 opened the door to comprehensive health care services to all veterans. Second, the national reputation and public perception of VA as a leader in the delivery of quality health care services has steadily risen, due in part to widespread acknowledgement of our major advances in quality and patient safety. Third, access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics. Fourth, our patient population is growing older and this has led to an increase in veterans' need for health care services. Fifth, VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our system. And finally, some feel that public disenchantment with Health Maintenance Organizations, along with their economic failure, may have caused many patients to seek out established and traditional sources of health care such as VA. All of these factors have put a severe strain on our ability to continue to provide timely, high-quality health care, especially for those veterans who are our core mission.

Through a combination of proposed regulatory and legislative changes, as well as a request for additional resources, our 2004 budget will help restore balance to our health care system priorities and ensure we continue to provide the best care possible to our highest priority veterans. The most significant changes presented in this budget are to:

—assess an annual enrollment fee of $250 for nonservice-connected Priority 7 veterans and all Priority 8 veterans;
—increase co-payments for Priority 7 and 8 veterans—for outpatient primary care from $15 to $20 and for pharmacy benefits from $7 to $15;
—eliminate the pharmacy co-payment for Priority 2–5 veterans whose income is below the pension aid and attendance level of $16,169;
—expand non-institutional long-term care with reductions in institutional care in recognition of patient preferences and the improved quality of life possible in non-institutional settings.

Revolutionary advances in medicine moved acute medical care out of institutional beds and rendered obsolete "bed count" as a measure of health care capacity. The same process is underway in long-term care and this budget proposes to focus VA's long-term care efforts on increased access to long-term care for veterans, rather than counting institutional beds. This budget focuses long-term care on the patient and his or her needs. Our policies expand access to non-institutional care programs that will allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

While we will shift our emphasis to non-institutional forms of long-term care, we will continue to provide institutional long-term care to veterans who need it the most—veterans with service-connected disabilities rated 70 percent or greater and those who require transitional, post-acute care. Coupled with this, our budget continues strong support for grants for state nursing homes.

In addition, we are working with the Department of Health and Human Services to implement the plan by which Priority 8 veterans aged 65 and older, who cannot enroll in VA's health care system, can gain access to a new "VA+Choice Medicare" plan. This would allow for these veterans to be able to use their Medicare benefits to obtain care from VA. In return, we would receive payments from a private health plan contracting with Medicare to cover the cost of the health care we provide. The "VA+Choice Medicare" plan will become effective later this year as the two Departments finalize the details of the plan.

Coupled with my recent decision on enrollment, these proposed regulatory and legislative changes would help ensure that sufficient resources will be available to provide timely, high-quality health care services to our highest priority veterans. If these new initiatives are implemented, veterans comprising our core mission population will account for 75 percent of all unique patients in 2004, a share noticeably higher than the 67 percent they held in 2002. During 2004, we will treat 167,000 more veterans in Priority Groups 1–6 (those with service-connected disabilities, lower-income veterans, and those needing specialized care).

In return for the resources we are requesting for the medical care program, we will be able to build upon our noteworthy performance achievements during the past 2 years. During 2002, VA received national recognition for its delivery of high-quality health care from the Institute of Medicine in the report titled "Leadership by Example." In addition, the Department received the Pinnacle Award from the American Pharmaceutical Association Foundation in June 2002 for its creation of a bar code medication administration system. This important patient safety initiative ensures that the correct medication is administered to the correct patient at the proper time. Patient satisfaction rose significantly last year, as 7 of every 10 inpatients and outpatients rated VA health care service as very good or excellent.

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We will employ this approach most extensively in the management of chronic disease and in disease prevention. For 16 of the 18 quality of care indicators for which comparable data from managed care organizations are available, VA is the benchmark exceeding the best competitor's performance.

Mr. Chairman, one of our most important focus areas in our 2004 budget is to significantly reduce waiting times, particularly for patients who are using our health care system for the first time. As we begin to rebalance our health care system with a heightened emphasis on our core service population, we will drive down waiting times. By 2004, VA will achieve our objective of 30 days for the average waiting time for new patients seeking an appointment at a primary care clinic. In addition, we have set a performance goal of 30 days for the average waiting time for an appointment in a specialty clinic. With this budget and the enacted funding level for 2003, we will eliminate the waiting list by the end of 2003.

We remain firmly committed to managing our medical care resources with increasing efficiency each year. The 2004 budget includes management savings of $950 million. These savings will partially offset the need for additional funds to care for an aging patient population that will require an ever-increasing degree of health care service, and rising costs associated with a sharply growing reliance on pharmaceuticals necessary to treat patients with complex, chronic conditions. We will achieve these management savings by implementing a rigorous competitive sourcing plan, reforming the health care procurement process, increasing employee productivity, increasing VA/DOD sharing, continuing to shift from inpatient care to outpatient care, and reducing requirements for supplies and employee travel.

Our projection of medical care collections for 2004 is $2.1 billion. This total is 32 percent above our estimated collections for 2003 and will nearly triple our 2001 collections. By implementing a series of aggressive steps identified in our revenue cycle improvement plan, we are already making great strides towards maximizing the availability of health care resources. For example, we have mandated that all medical facilities establish patient pre-registration to include the use of software that assists in gathering and updating information on patient insurance. We are in the midst of a series of pilot projects at four Veterans Integrated Service Networks to test the implementation of a new business plan that calls for reconfiguration of the revenue collection program by using both in-house and contract models. In addition, the Department will award the Patient Financial Services System this spring to Network 10 (Ohio) which will acquire and deploy a commercial system of this type. This project involves comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DOD) to enhance the coordination of the delivery of benefits and service to veterans. Over the past year, our two Departments have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a Joint Executive Council (JEC). To expand the scope of interdepartmental cooperation, a benefits committee has been added to complement the longstanding Health Executive Council. The VA and DOD Benefits Executive Council is exploring improved transfer and access to military personnel records and a pilot project for a joint physical examination to improve the claims process for military personnel. The JEC provides overarching policy direction, sets strategic vision and priorities for the health and benefits committees, and serves as a forum for senior leaders to oversee coordination of initiatives. To address some of the remaining challenges, the Departments have identified numerous high-priority items for improved coordination such as the joint strategic mission and planning process, computerized patient medical records, eligibility and enrollment systems, joint separation physicals and compensation and pension examinations, and a joint consolidated mail-out pharmacy pilot.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The 2004 budget includes $225 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative. This program addresses the needed infrastructure realignment for the health care delivery system and will allow the Department to provide veterans with the right care, at the right place, and at the right time. CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access.

As demonstrated in Veterans Integrated Service Network 12, restructuring will require significant investment to achieve a system that is appropriately sized for our future. Our preliminary estimate for resources that can be redirected to medical care between now and 2010 as a result of the appropriate alignment of assets and health care services, and the sale or enhanced-use leasing of underutilized or nonperforming assets, is $6.8 billion. It is extremely important to have funding in 2004 to begin the multiyear effort to restructure. Given the timing associated with identifying CARES projects, we will be working with your committee on the authorization process in order not to delay the start of these projects.

MEDICAL AND PROSTHETIC RESEARCH

Mr. Chairman, we are requesting $822 million in funding for VA's clinical research program, an increase of 2.6 percent from the 2003 level. For the first time, our request includes funds in the form of salary support for clinical researchers, resources that previously were a component of the Medical Care request. This approach provides a more complete picture of VA's resources devoted to this program.

In addition to the Department's funding request, nearly $700 million in funding support comes from other federal agencies such as DOD and the National Institutes of Health, as well as universities and other private institutions.

This $1.5 billion will support more than 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, diabetes, heart disease, chronic viral diseases, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

VETERANS' BENEFITS

The Department's 2004 budget request includes $33.7 billion for the entitlement and discretionary costs supporting the six business lines administered by the Veterans Benefits Administration (VBA). Within this total, $1.17 billion is included for the management of these programs—compensation; pension; education; vocational rehabilitation and employment; housing; and insurance.

Improving the timeliness and accuracy of claims processing is a Presidential priority, and during the last year we have made excellent progress toward achieving this goal. A year ago, I testified that I had set a performance goal of processing compensation and pension claims in an average of 100 days by the summer of 2003. I am pleased to report that we are on target to meet that goal and we will maintain that improved timeliness standard for 2004. When we reach this goal, we will have reduced the time it takes to process claims by more than 50 percent from the 2002 level.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2004 performance goal for the national accuracy rate is 90 percent, a figure 10 percentage points higher than last year's level of performance, and markedly above the accuracy rate of 59 percent in 2000.

The driving force that will allow us to make this kind of progress with only a slight budget increase continues to be the initiatives we are implementing from the Claims Processing Task Force I established in 2001. Located at the Cleveland Regional Office, our Tiger Team has been working over the last year to eliminate the backlog of claims pending over 1 year, especially for veterans 70 years of age or older. This aggressive effort of reducing the backlog and improving timeliness is underway at all of our regional offices. VBA has established specialized processing teams, such as triage, pre-determination, rating, post-determination, appeals, and public contact. Other Task Force initiatives, such as changing the procedure for remands, revising the time requirements for gathering evidence, and consolidating the maintenance of pension processing at three sites, have allowed us to free up resources to work on direct processing at the regional offices.

This budget includes additional staff and resources for new and ongoing information technology projects to support improved claims processing. We are requesting $6.7 million for the Virtual VA project that will replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. We are seeking $3.8 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process. In addition, we are requesting $2.6 million in 2004 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

In support of the education program, the budget proposes $7.4 million for continuing the development of the Education Expert System. These resources will be used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment certification. This initiative will contribute toward achievement of our 2004 performance goal of reducing the average time it takes to process claims for original and supplemental education benefits to 27 days and 12 days, respectively.

VA is requesting $13.2 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will allow us to answer calls at any place and at any time without complex call routing devices.

All of these information technology projects are consistent with the Department's Enterprise Architecture and will be supported by improved project administration from our Chief Information Officer.

BURIAL

The President's 2004 budget includes $428 million for VA's burial program, which includes operating and capital funding for the National Cemetery Administration (NCA), the burial benefits program administered by VBA, and the State Cemetery Grant program. This total is $17 million, or 4.2 percent, over the 2003 level.

This budget request includes $4.3 million for the activation and operation of five new national cemeteries in 2004. NCA plans to open fast-track sections for interments at four new national cemeteries planned for Atlanta, South Florida, Pittsburgh, and Detroit. Fort Sill National Cemetery opened a small, fast-track section for interments in November 2001, and Phase 1 construction of this cemetery should be complete by June 2003. In addition to resources for these five new cemeteries, this budget request also includes resources to prepare for the future opening of a fast-track section of an additional national cemetery near Sacramento. The locations of these national cemeteries were identified in a May 2000 report to Congress as the six areas most in need of a new national cemetery.

With the opening of these new cemeteries, VA will increase the proportion of veterans served by a burial option within 75 miles of their residence to nearly 82 percent.

The $108.9 million in construction funding for the burial program in 2004 includes resources for Phase 1 development of the Detroit cemetery, expansion and improvements at cemeteries in Fort Snelling, Minnesota and Barrancas, Florida, as well as $32 million for the State Cemetery Grant program.

The budget request includes $10 million to support the Department's commitment to ensuring that the appearance of national cemeteries is maintained in a manner befitting a national shrine. One of the key performance goals for the burial program is that 98 percent of survey respondents rate the appearance of national cemeteries as excellent.

A new performance measure established for NCA is marking graves in a timely manner after interment. We have established a 2004 performance goal of marking 75 percent of graves in national cemeteries within 60 days of interment. When we achieve this goal, it will represent a dramatic improvement over the 2002 level of 49 percent.

MANAGEMENT IMPROVEMENTS

Mr. Chairman, we have made excellent progress during the last year in implementing, or developing, several management initiatives that address our goal of applying sound business principles to all of the Department's operations. We are particularly pleased with our accomplishments in addressing the President's Management Agenda that focuses on strategies to improve the management of the Federal government in five areas—human capital; competitive sourcing; financial performance; electronic government; and budget and performance integration.

We have developed a sound workforce and succession plan that includes strategies VA will pursue to implement a more corporate approach to human capital management, and a workforce analysis of several of the Department's critical positions—physicians, nurses, and compensation and pension veterans service representatives. We are moving forward with a competitive sourcing study of our laundry service, and other studies will be conducted of our pathology and laboratory services, and facilities management and operations. With regard to financial performance, we achieved an unqualified audit opinion for the fourth consecutive year. During 2003 and 2004, we will be involved in 10 electronic government studies. And finally, we continue to progress in our efforts to better integrate resources with results. One major accomplishment in this area is the restructuring of our budget accounts. This new account structure is presented in our 2004 budget and will lead to a more complete understanding of the full cost of each of our programs.

VA has a variety of other management improvement efforts underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes. I am committed to reforming the way we conduct our information technology (IT) business, and to help the Department meet this objective, we have aggressively pursued new approaches to accomplishing our IT goals. We have developed a One-VA enterprise strategy, embarked on a nationwide telecommunications modernization program, and laid a solid foundation for a Departmental cyber security program. In order to facilitate and enhance these efforts, I recently centralized the IT program, including authority, personnel, and funding, in the office of the Chief Information Officer. This realignment will serve to strengthen the IT program overall and ensure that our efforts remain focused on building the infrastructure needed to better serve our Nation's veterans.

This budget includes $10.1 million to continue the development of the One VA Enterprise Architecture and to integrate this effort into key Departmental processes such as capital planning, budgeting, and project management oversight. Our request also includes $26.5 million for cyber security initiatives to protect our IT assets nationwide. These initiatives aim to establish and maintain a secure Department-wide IT framework upon which VA business processes can reliably deliver high-quality services to veterans.

The 2004 budget includes funds to continue the CoreFLS project to replace VA's existing core financial management and logistics systems—and many of the legacy systems interfacing with them—with an integrated, commercial off-the-shelf package. CoreFLS will help VA address and correct management and financial weaknesses in the areas of effective integration of financial transactions from VA systems, necessary financial support for credit reform initiatives, and improved automated analytical and reconciliation tools. Testing of CoreFLS is underway, with full implementation scheduled for 2006.

We are developing a realignment proposal for finance, acquisition, and capital asset functions in the Department. A major aspect of this effort centers on instituting much clearer delegations of authority and improved lines of accountability. This plan would establish a business office concept across the Department and would enhance corporate discipline that will lead to uniformity in operations and greater accountability, and will make the transition to the new financial and logistics system much easier to implement. A component of the plan under review and consideration will result in a consolidated business approach for all finance, acquisition, and capital asset management activities.

CLOSING

Mr. Chairman, I am proud of our achievements during the last year. However, we still have a great deal of work to do in order to accomplish the goals I established nearly 2 years ago. I feel very confident that the President's 2004 budget request for VA will position us to reach our goals and to continue to provide timely, high-quality benefits and services to those who have served this Nation with honor.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

Senator BOND. Thank you very much, Mr. Secretary. Senator Mikulski has been summoned to a very important meeting, so I am going to let her ask questions as long as she wishes, as long as she needs, and then I will finish up with what is left.

Senator MIKULSKI. I thank the chairman for his courtesy. I am part of a bipartisan special project task force under Senator Frist and have to leave shortly, but let me get right to my questions, Mr. Secretary, and it goes to the issues related to the management of the number of veterans coming in for prescription drugs.

Let me go right to the IG report. In the IG report, they discussed in great detail about priority 7. They said 90 percent of those who come had either access to private non-VA health care, they had health insurance to see a doctor, but they did not have health insurance to get their prescription drugs. The IG recommended a change—and they were coming to VA to get their prescription filled, but it was not written by a VA doctor.

The IG recommended a change in the law so that veterans could have privately written prescriptions filled by the VA, and it was the original estimate by the IG that VA could save $1 billion a year by doing this. Now, this seems like a solution that would deal with, where you are not going being overwhelmed in the primary care department, and yet also meet those needs.

Could you tell me, Mr. Secretary, or your team, Dr. Roswell, have you looked at this, and what do you think about the IG's recommendation, and would it be good patient care, and would it be good stewardship over our financial resources?

Secretary PRINCIPI. Let me begin, because it is a very timely issue and one we are seriously grappling with. I do not say that lightly. I have been spending a lot of time, we spent a lot of time on this issue yesterday, and it is one of concern to us, and I will let Dr. Roswell follow up, but I think the concern, Senator Mikulski, is if we go down this road and basically just fill prescriptions, we do not know where it will lead.

Although the growth in the VA workload has increased dramatically, as we all talked about here earlier, we are still seeing a microcosm of the 25 million veterans, and there are a lot more Medicare-eligible veterans out there, and if we became something akin to a drugstore, although I do not care for that term, we do not know what kind of influx we would have and how we could possibly support financially that increased workload of just filling prescription drugs.

We are already stretched kind of to the limit, moved so much of our resources into primary care. If we had an influx of, let us say, 1 million or 2 million Medicare-eligible veterans who have never sought their care from the VA, how would we fund that?

I think that is the only real disagreement. Perhaps it is a projection issue with the IG. I commend them for their report, but it is something that we are looking at at least right now to deal with the backlog issue, veterans who are currently on the backlog, to see if there is something we could do there, to fill their prescriptions.

Senator MIKULSKI. But if I could just jump in, because the time is ticking here, you say you are worried that you will be overwhelmed by more people. The IG says, though, by doing this you are going to save $1 billion. That is a big bucket of change, and also has an impact on the number of primary care visits.

Dr. Roswell, first would it save money, and second, would it help you with the staffing, and if not, why, because the IG usually has some pretty good recommendations.

Dr. ROSWELL. The IG made a very astute observation. In fact, based on the unprecedented and unpredictable demand for care the IG is currently in the process of amending their recommendations and, in fact, the savings may exceed $2 billion a year.

The savings come from replication of physical examination services and primary care services that have been provided by non-VA providers in the community, that now by law must be provided by the VA again before we can issue prescription drug benefits, and while we do not argue with the savings that the IG talks about in his study, it is important to point out that those are savings associated with replicated or duplicated physical examination and patient care services, but it does not reflect the incremental cost to our medical care appropriation for the additional pharmaceutical product that would be consumed by those people once prescriptions are issued by the VA.

Last year, a typical patient in priority 7 or 8 received over $750 in prescription products. Now, seeing a patient once or twice a year, which would be necessary to evaluate them and rewrite the prescriptions written by their non-VA provider, would conservatively cost between $150 and $200 a year, but if we save $150 or $250 a year and then turn around and spend an additional $750 on pharmaceutical product, the impact on the appropriated dollar

is phenomenal, so the savings are really more than offset by the additional cost of the drugs.

Senator MIKULSKI. Well, first of all, from what I could see, any change would require statutory and regulatory change. Before we embark upon that, though, I think we need some recommendations that are consistent from both the VA itself and the VA IG, because I think we are onto something, but we want to be sure that the something leads to good care and to cost savings that do not reduce care, therefore maximizing the role that private insurance plays in our system.

You already have a consistent problem collecting money from private insurance.

Secretary PRINCIPI. Yes.

Senator MIKULSKI. They always kind of dance us around.

Secretary PRINCIPI. That is correct.

Senator MIKULSKI. However, if you are going to your primary care doctor with whom you have a relationship and that primary care doctor also has a relationship with your spouse, that is a good place for the veteran to be, because it is holistic, it is family-oriented, they probably have known that vet since he or she came back home so we just need to see, then, how we can maximize this, and do that.

I really think this could be a very important tool as we get to our appropriations, while we are then working for a national program, so I would like us to take a look at it. I am not committed to this method, but I am committed to us examining this recommendation and coming up with perhaps, not a compromise, but a balanced approach where you all feel very good about it.

ENROLLMENT FEE

Let me go on, then, to another issue, which goes to the $250 enrollment fee. How did you arrive at $250? It is essentially like a deductible. How did you arrive at it, and why do we need it?

Secretary PRINCIPI. Well, again I think we looked at, in assessing what would be an appropriate enrollment premium for the higher income, I think we looked at the potential savings from those who may have some other options, who may have insurance, but may use the VA on a periodic basis. We looked at the TRICARE program. We looked at what the assessment is for military retirees who spend 20 or 30 years in uniform to be enrolled in the TRICARE Prime program.

Senator MIKULSKI. They have to pay an enrollment fee?

Secretary PRINCIPI. Yes. Yes, they do.

Senator MIKULSKI. How much is that?

Secretary PRINCIPI. It is $456 a year for a married couple and I believe it is probably around $250 for a military retiree who has no spouse, but usually it is a family. It is a $456 a year payment, so here on the one hand we have a military retiree with 20 or 30 years of service is required to make a payment, and we thought that it would be reasonable, just for this, again the nondisabled, higher-income, those who may have spent 2 years or 4 years on active duty, to make a payment of $250, so that is how we reached it.

We looked at the potential revenues, the savings that you allow us to keep at the VA medical center where it is collected so that we can provide more health care, and we looked at what was comparable in other Federal sectors.

Senator MIKULSKI. Well, this is going to be a little touchy, but did the VA decide on an enrollment for cost reasons, or did you also think by an enrollment, it would also be a deterrent for those people to come to you?

Secretary PRINCIPI. No, clearly I think there is some suppression, Senator Mikulski. For people who have no option, $250 is the greatest deal in the world, even in America. When the average cost is about $4,000 a year, for that individual to pay $250 is a very, very small percentage, and for a very rich benefit as well, I might add.

But for those who do have other options, are insured by Blue Cross or Blue Shield, or have TRICARE coverage through the military, they might say, well, it does not pay for me to spend $250 a year. I can just go ahead and stick with my current insurance program. So, indeed, there is a suppression.

Senator MIKULSKI. It would give a pause.

Secretary PRINCIPI. I'm sorry.

Senator MIKULSKI. It would give a pause, an analysis.

Secretary PRINCIPI. Yes.

Senator MIKULSKI. Well, I know that these are other issues the chairman will ask about as well. I have other questions I would like to submit to the record, but let me go to the last question, and it goes, first, what are we doing for gulf war veterans, and second, tell me what the VA is doing as we look at what we are about to face in Iraq and what we continually face here in the war on terrorism.

GULF WAR LESSON

I am absolutely delighted about your collaboration with Secretary Thompson. I cannot encourage you more for both ideas, efficiencies, good policies, et cetera, but we are facing serious issues on bioterrorism and possibly chemical terrorism, possibly even something as repugnant as a dirty bomb. Where does the VA come in? So thinking about our gulf war veterans, what they were subjected to in that hot desert, they are going right back out there again. What are we doing for the ones here, what are we getting ready for, God forbid, if they come back sick, and second, what is the VA doing in the war against terrorism?

Secretary PRINCIPI. Senator, I harken back to my days riding river boats in the Mekong Delta, Vietnam, and the whole issue of Agent Orange, so I get pretty personally sensitive to this issue, and when I came on board I said I just did not want to repeat the mistakes of the past with regard to the Persian Gulf, and so I think we have really taken a very fresh look at it, appointed a new advisory committee of people who sometimes think out of the box and explore unconventional theories. That is not to say I reject conventional theories.

You know, I immediately service-connected when we had some evidence of veterans with Lou Gehrig's disease. One of my predecessors, my good friend, Jesse Brown, died of ALS, and we service-

connected the veterans who served in the gulf between 1990 and 1991 with ALS. I recently directed that we service-connect veterans with chronic lymphocytic leukemia, and I just asked the Institute of Medicine to take a look at the Sarin gas that was exposed when we hit the Kamisiyah ammunition dump in Iraq and some Sarin gas was released into the atmosphere to see if there are long-term chronic effects.

So we are continually, continually looking at this issue to see what caused these illnesses and to try to apply those lessons now to the Persian Gulf, Iraq II, and I will let Dr. Roswell talk about the things he is doing with the Department of Defense to make sure.

Senator MIKULSKI. And I am also mindful of time, so if we could——

Dr. ROSWELL. Very briefly, it is an excellent point. We are working with unprecedented collaboration not only with HHS, but with the Department of Defense. There is a Joint Executive Council and a Health Executive Council with the Deployment Health Group. It is managed between the two Departments. We have communicated clearly and consistently with DOD what we believe the needs are. They are fully supportive of those needs.

Specifically, we are making a maximal effort to do predeployment surveys of all personnel going to the gulf who may be involved in a war with Iraq. That predeployment survey assesses premorbid conditions, health status at the time they are deployed.

We also have an aggressive level of monitoring in theater, looking not only at incidents after they occur, but also doing proactive monitoring before an incident occurs. That information will be shared with VA as soon as it can be declassified and made available.

We will be doing a post-deployment survey as well to assess their health at the time they are separated and redeployed back to the United States. There is also a serum repository in which virtually every military personnel deploying to the gulf theater will have a serum sample that is no more than 1 year old placed in that national serum repository, and that will be available for testing after a conflict in the gulf war should it be needed.

So there is really an awful lot of collaboration.

Senator MIKULSKI. What about the war on terrorism? There are 162 VA hospitals. Many of them are in high-threat areas. Are you participating with the CDC in terms of the national preparation for a possible biological attack on our citizens? Are the VA employees getting the vaccines? What is the role of the VA in being part of a network?

Second, you are under the command and control of the United States of America. You are very different from any of the other health care, you are different from any other acute care facilities, because you are essentially, in terms of administration, management, and even national public directive, you are a one-stop shop.

Dr. ROSWELL. We have a very high level of cooperation with the new Department of Homeland Security. We participate in the National Disaster Medical System. We have created new Federal partners: that was actually an innovation of Secretary Principi to work with other Departments in that response.

VA has issued pharmaceutical caches at our critical locations.

Senator MIKULSKI. Are you getting the smallpox vaccine?

Dr. ROSWELL. We have smallpox vaccine.

Senator MIKULSKI. Have the workers been vaccinated?

Dr. ROSWELL. A very small number have been vaccinated.

Senator MIKULSKI. In the event of a casualty, like in a city like Baltimore, or New York, or San Francisco, would the VA hospitals there be prepared to deal with the casualties, and are you part of the network that is going on in those individual towns?

Dr. ROSWELL. We are a part of the network and we are taking appropriate steps to be prepared, with protective equipment, with decontamination equipment.

Senator MIKULSKI. Well, I appreciate that, but right now at Johns Hopkins, the University of Maryland and other hospitals, they are getting vaccinated, and they are asking for volunteers to do it. It is a very complicated situation. I have my own flashing yellow lights about it, but is the VA as active as the local community hospitals?

Dr. ROSWELL. VA personnel receive the smallpox vaccine in two different ways. We have actually requested our own supply of vaccine which HHS has promised to make available to us. We are also participating by the States—the CDC vaccination plan for smallpox, you may recall, is on a State-by-State——

Senator MIKULSKI. Maybe I am asking this at the third paragraph. Are you going to be one of the hospitals that will be designated to be one of the primary facilities accepting this, or if there is a smallpox outbreak, are they going to go to community hospitals and VA is not going to be involved?

Dr. ROSWELL. If the President activates the Federal Response Plan, the VA will be able to respond through the National Disaster Medical System.

Senator MIKULSKI. What about the local medical system?

Secretary PRINCIPI. Well, just as during 9/11, I made our facilities in New York City available to treat casualties, and I would do precisely the same thing if something should happen in Baltimore or Kansas City, or wherever disaster might hit. If the resources of the VA are needed to assist the community in responding, we will be prepared to do so.

Senator MIKULSKI. Mr. Chairman, you have been more than generous. I think these are things that we need to continue to pursue.

Thank you, and we look forward to working with you.

Senator BOND. Thank you, Senator Mikulski. You raised many good questions.

Going back to the prescription drug questions that Senator Mikulski asked, I have heard stories that large companies have sent out memoranda to huge numbers of their employees who might be veterans telling them that they are entitled to get prescription drugs from the VA. Now, this would not be illegal. As a matter of fact, this would be provided, but can you tell me, have you heard of such an example?

Secretary PRINCIPI. Yes, Mr. Chairman, and I have received a copy of a memo that was prepared by an individual who manages the medical care prescription drug benefit for one of the Nation's

largest and most prestigious Fortune 500 companies recommending to his superiors at this company that——

Senator BOND. IBM, I believe.

Secretary PRINCIPI (continuing). IBM, that there are 50,000 employees of the company who are veterans, and that the corporation could save enormous health care costs, prescription drug costs if the employees used the VA health care system for that benefit, so I do not know if that memo was approved by the higher-ups at that company, but certainly it was of great concern to us, because we do not believe that that is what was intended by eligibility reform, but nonetheless, it is perfectly legal for employees of any corporation to go seek, get their health care from the VA, but it just points out the enormous demand that is being placed upon us.

Senator BOND. Any company that has an opportunity to lessen health care costs, if it is within the law—I may not agree with it from a policy standpoint, but the law provides it, and that is why I think it is absolutely essential that we build into the law some protections for the core constituencies, those that do not have other prescription drug options, and so we do not have people with other, with higher incomes, no service-connected disabilities, crowding out the core constituents.

Just to follow up another question, Dr. Roswell I think answered and raised some good points about the IG report, but if you were to consider the IG report as allowing only already-enrolled priority 1 to 6 veterans to have their private physician phone in or direct their prescriptions to the VA pharmacy, would that save some time? Maybe those people are only getting their prescriptions from VA doctors, but is there a smaller potential savings in that group?

Dr. ROSWELL. There is a potential savings. The concern I think I have is that if we made that benefit available to currently enrolled priority 1 through 6 veterans we would have no way to curtail the demand for new enrollment in those priorities that such a benefit might create, and again, I mean, as the Secretary said, this is an area where we are getting into uncharted waters. We simply do not know, but certainly we are actively exploring a number of options.

Senator BOND. As my colleague from Maryland indicated, we obviously want to work with you. These are uncharted territories. It may be a good idea, it may not.

Speaking of those ideas, I have heard from a number of health care policy gurus, when I have been involved in health care debates, that having an appropriate and affordable co-pay ensures responsible use of the prescriptions. In other words, if you have to put cash on the barrelhead, then you only get the prescriptions that you intend to use, and you take care of them and make sure you do not flush them, or drop them, or lose them, and that it has an impact on the responsibility of use. Do you believe this is a valid principle?

Dr. ROSWELL. Mr. Chairman, I think you make an excellent point. It certainly is a valid principle, and we have tried to incorporate that in some of the policy recommendations in the 2004 budget proposal.

RAISING OF COPAYMENTS

Senator BOND. There have been some questions about raising the co-pay from $7 to $15. If you could not raise the copayment, or did not have the copayment, what impact would that have (a) on usage, the number of people using it, and (b) what would be the additional dollar cost without that co-pay?

Dr. ROSWELL. Our estimates are that by increasing the prescription co-pay from $7 to $15 for priorities 7 and 8 that we would obviate the need for almost $250 million in appropriated medical care dollars in 2004, so it is fairly significant.

Senator BOND. Do you happen to know how much of that is the fees actually collected, and how much of that results from what might euphemistically be characterized as suppression?

Dr. ROSWELL. $181 million would be what you call suppression, decreased usage, $65 million would be increased collections, for a net offset of the appropriation of $246 million, estimated.

WAITING LISTS

Senator BOND. With respect to the waiting lists, some advocates have said that we need more staff for the VA, but looking at the GAO report, the GAO was rather critical, saying many of the delays, the waiting lists were the result of poor scheduling procedures and inefficient use of staff.

Now, some of the clinics I think are apparently making good progress working with the Institute for Health Care Improvement to develop strategies to reduce waiting time. Can you describe what kind of actions you have taken and any response you have to the GAO report?

Dr. ROSWELL. You are absolutely correct. In fact, I was in Boston the day before yesterday working with Don Berwick and the Institute for Health Care Improvement, where we have a major ongoing meeting on advanced clinic access. This is a series of actions to more effectively schedule care and better utilize the existing primary and specialty care capacity we have.

We have got senior leadership from all over the Nation participating on this collaborative effort. It is an ongoing series, and we have really been able to achieve some remarkable results in improving panel size, in improving access to care using a very finite resource.

Let me point out that since enrollment, as you pointed out in your opening remarks, we have doubled the number of veterans we are caring for and yet today our workforce is actually smaller than it was in 1986, so it is fairly remarkable that we only have 200,000 people on a waiting list. We are working with IHI and the advanced clinic access principles to improve that. We have a new electronic waiting list. We have a major physician and nursing recruitment initiative, coupled with the 2004 budget that we plan to pursue as well.

Senator BOND. Do you have an idea, in percentage terms, how much the new procedures, the IHI procedures could reduce the waiting list or improve efficiency, or is that still in the works?

Dr. ROSWELL. I do not have it in actual percentage terms. Let me point out, though, that in July of last year, we had 317,000 people

on a waiting list. We were able to take over 200,000 people off that waiting list during a period we were on a Continuing Resolution and we were operating on a fiscal year 2002 funding level. I think that speaks to the potential of the advanced clinic access for improving our efficiency.

Senator BOND. Mr. Secretary, I expressed my views on what apparently was found to be going on at Lexington, Kentucky VA med center. Can you briefly summarize your response to that audit, and can you discuss whether this practice exists at other VA facilities?

Secretary PRINCIPI. Sure. Well, this is a very, very troubling issue for me, Mr. Chairman, and I am obviously deeply concerned by the preliminary findings in Lexington. I have not seen a final report by the IG, but obviously if the allegations are borne out then in and of itself at that facility it is a serious, serious problem, and it needs to be addressed, but based upon a national audit, that also has not been finalized—I have a copy of the draft report on my desk—it really points out an institutional problem.

I am very, very supportive of the affiliations. I think medical education and the VA have been able to make tremendous advances in health care delivery and research. However, I find it completely unacceptable to have doctors who are being paid by the VA with veteran dollars, taxpayer dollars who are not doing the work that they are being paid to do, and at the same time we have long waiting lists.

This culture of subsidization to the medical schools simply has to stop, and all I ask for is equity, but as I intend to be held accountable, I intend to hold my leadership accountable to correct this problem once and for all, and we will be taking some decisive steps, hopefully in a very constructive way, to address this issue and ensure that all physicians, part-time, full-time, are devoting the time necessary to their responsibilities for which they are being paid by the American people.

Senator BOND. I was stunned by the revelation. I do believe that the medical school collaboration has tremendous benefits. I know that you attract good quality physicians where they can work with a university in addition to serving patients, but I am appalled, as you were. I think that if this system is found to exist, I would think that the VA might ask for repayment of some of those reimbursements.

Secretary PRINCIPI. Oh, I certainly will demand a repayment wherever it is found that the work was not performed.

I would add, you know, I have traveled this country a great deal over the past 2 years, and we have been together in Missouri——

Senator BOND. Sure.

Secretary PRINCIPI (continuing). and the overwhelming number of our physicians are loyal, dedicated public servants. In many, many cases they do more than is expected of them, and it is a travesty that there is a certain percentage that are undermining the VA's great strengths, and it needs to end, and this culture needs to change, and again bring this situation back in balance and to get on with caring for veterans. That is our first and primary mission, patient treatment, treating veterans, and everything else is there to support it, to ensure that we have the right doctors, the

most professional, highly skilled physicians, and so, it is an issue that I will report to you on, Mr. Chairman.

Senator BOND. We appreciate that.

Secretary PRINCIPI. Be assured that we take it very seriously.

Senator BOND. When will the national audits be published? When will that come out?

Secretary PRINCIPI. I expect quite soon, perhaps as early as next month. The IG is here, and he might be able to provide additional information. This is a report I asked for.

Mr. GRIFFIN. The report went to VHA about 3 weeks ago. The normal response time is 30 days. Sometimes that gets stretched out a little bit, but we would hope to issue the final within 30 days.

Senator BOND. Thank you very much. I hope, as you do, that this is an isolated problem, but it has got to end, and certainly I have seen the doctors who work and serve VA patients and also are serving in the medical schools, we cannot lose that, but this system has to stop.

On the staffing question, Dr. Roswell, in 1991 the Institute of Medicine provided suggestions to VA on staffing standards, and in January of last year Congress enacted legislation requiring VA to establish staffing standards. It appears that has been delayed. I would like to know why. Without staffing standards, how do we know what type of physicians are needed where?

Dr. ROSWELL. First of all, let me assure you that efforts to comply with the requirement are well underway. We expect the staffing standards to be reported back to us within the next 60 days or so, so they are in progress.

Staffing standards in health care, let me point out, is a very difficult subject, as even the IOM has pointed at in previous reports. We use a variety of ways to assess current staffing needs, but admittedly they are based on access-to-care issues, so where we have greater waits for clinics, where we have waits for procedures or types of specialty services is where we focus our staffing requirements. The staffing standards we hope will help us improve productivity, and we look forward to those, as do you.

Senator BOND. Thank you, sir.

Let us see, I am told that the DOD has staffing standards. Are you learning from them?

Dr. ROSWELL. We have looked at DOD staffing standards, and maybe we should take a lesson. DOD does not use part-time physicians, which has all the attendant problems we just discussed, but sometimes the staffing standards that DOD uses do not translate to VA's pattern of health care delivery directly, but we certainly are looking at those.

Senator BOND. Moving on to another subject I addressed about the inconsistency among VISNs, as I said, Mr. Secretary, I supported Dr. Kaiser's changes. I am concerned that decentralization has gone too far. There is inconsistent compliance with pharmaceutical policies. Is there too much freelancing going on among divisions? I hate to use the word fiefdoms, but that seems to come to mind.

Secretary PRINCIPI. Well, I think there is always a little tension, if you will, between centralization and decentralization. Perhaps early on there was a move toward more decentralization, and it re-

sulted in 21 or 22 network directors perhaps moving off in different directions, and not recognizing the importance of the whole, so to speak, and I recognize, too, that neither Dr. Roswell nor I can manage the VA health care system from Washington, D.C. You need strong leaders out in the field, closest to the patient, to the veteran, to make those day-to-day decisions.

However, there needs to be one policy and one direction, and everybody needs to be marching in the same direction, and that was not the case. We have had 22 networks competing against one another, competing out there in enrollment drives so that this network would do better than the network next door in terms of the VERA allocation dollars, and lots of other areas as well, and I think we have strengthened the oversight, we have strengthened the direction, and that people understand that policy is made in Washington. We expect them to adhere to that policy, and within that, they are to manage the system.

Senator BOND. I thought the policy of decentralization was great, and I think maybe you have hit the right note on that.

I am going to finish up, because I know you have other commitments, and I know you would be disappointed if I did not submit some questions for the record so I will not give you a chance to answer all of them here. I would like to ask you what is the status of the CARES project? I really appreciate your request to jumpstart CARES. What is your funding priority? How much do you think this could save in costs to be redirected to health care services for veterans?

Secretary PRINCIPI. Well, I think it is one of the most important undertakings that the VA has embarked on in a long time. It is on track, Mr. Chairman. I expect to have a report on my desk in early October with the recommendations of the commission. I will make a decision based on that report shortly thereafter.

I think the savings can be significant, savings that can be used, if you will, to truly expand the reach of health care and the manner in which health care is being delivered in America today, and it would probably take an investment up front to realign the system, if you will, to move us in the right direction. I do not have a dollar figure now, but I do believe that our request is a good down payment for the CARES process.

I would only highlight, Mr. Chairman, I know your strong interest in this issue, and I would never spend money on a facility I know needs to change its mission, but we have an aging infrastructure out there, and it is beginning to deteriorate, and we need to get on with making some needed repairs in some areas.

As you know, Kansas City was a good example of some of the things that we needed to do, so I am anxious to get this process completed and get a report up to you, and hopefully we can then find the dollars to make the necessary changes.

Senator BOND. I certainly hope so.

One last question. You have a decentralization problem. I have a decentralization problem. There are 50 different States represented in the Senate, and every single one of them needs a new cemetery. The VA recently completed the national shrine study. Can you tell me about the study, and the VA's process for prioritizing funding requests for the cemeteries?

Secretary PRINCIPI. Well, certainly we have a very aggressive schedule of opening new cemeteries. We have four new cemeteries that are in the process, and a fifth one in the advanced planning stage. That is the Sacramento cemetery.

The cemetery study did point out some deficiencies in a number of our cemeteries. The Acting Under Secretary is in the process now of prioritizing our needs, and deciding which ones are the most important, but there is a lot of maintenance and repair that needs to be made to many of our national cemeteries. The dollar figure is quite high. We have a small down payment towards that effort.

Do you have anything to add, Eric, on the cemetery, the national shrine?

Mr. BENSON. Mr. Chairman, we have instituted a set of standards for operations and appearances in our national cemeteries which will include the new national cemeteries we are opening. We believe those standards will enable our employees, who are very dedicated, to bring cemetery appearances up to standard, as well as to provide us with the prioritization of cemeteries in the States that you mentioned.

Senator BOND. Well, Mr. Secretary, unless you want to add anything, I think to enable us to get on with our schedules, we will submit the rest of the questions for the record. We appreciate the answers from you and your staff. Obviously, we have a lot of challenges and work ahead of us. We look forward to continuing to work with you to meet those challenges to continue to improve the viability of our service to the veterans.

ADDITIONAL COMMITTEE QUESTIONS

Secretary PRINCIPI. The only thing I would like to add, Mr. Chairman, is just to congratulate you on the receipt of a very prestigious VFW award last evening, an award truly deserved for your enormous support for our agency. We thank you, very, very much.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO THE DEPARTMENT OF VETERANS AFFAIRS

QUESTIONS SUBMITTED BY SENATOR CHRISTOPHER S. BOND

COST-SHARE PROPOSALS

Question. Your fiscal year 2004 budget request proposes to charge a $250 annual enrollment fee and raise the prescription copayment from $7 to $15 for Priority 7 and 8 veterans. Both of these initiatives require legislative action.

If these legislative proposals are not enacted, how much more money will we need in fiscal year 2004 for the medical care account to eliminate the waiting list? Have you considered other options to address the waiting list problem?

Answer. VA's fiscal year 2004 budget contains several policy proposals that will allow the VA health care system to refocus on better meeting the needs of our core population, veterans with service-connected disabilities, veterans with lower incomes, and veterans with special health care needs. Since eliminating the wait lists is closely tied to all our efforts to refocus the system, failure to enact any or all these proposals could adversely impact our ability to eliminate the wait lists.

The table below provides the additional appropriations resources that would be required in 2004 if Congress denied the medical care policies proposed in the 2004 President's budget.

IMPACT OF CONGRESSIONAL DENIAL OF PROPOSALS ON APPROPRIATION

(Dollars in millions)

Policy	2004 Appropriation
Stop new enrollment of P8 veterans	−$335.2
Assess $250 annual enrollment fee for NSC P7 and Enrolled P8s	−531
Increase Outpatient Primary Care Copay from $15 to $20 NSC P7 and Enrolled P8s	−14.7
Increase Pharmacy Copay from $7 to $15 for NSC P7 and Enrolled P8s	−245.6
Increase Copay, Threshold to Aid and Attendance Level	+33.0
Limit Long-Term Care benefits to P1a Veterans	−222.4
Bill HMOs and PPOs	−69.0
Total	−1,384.9

WAITING LIST

Question. Some advocates believe that additional funding for more staff is the answer to solving the waiting list problem but GAO reported, "given the inefficiencies we found, it was difficult to determine the extent to which clinics would have benefited from additional staff." GAO also found that many of the delays were the "result of poor scheduling procedures and inefficient use of staff." Some clinics were making noteworthy progress in reducing waiting times through management reforms because of collaborative work with the Institute for Healthcare Improvement (IHI)—a private contractor that was retained to develop strategies to reduce waiting times.

Can you briefly discuss what actions you have taken to address the waiting list problem, including your response to GAO's findings? How will you ensure that the VISNs will implement the IHI reforms?

Answer. We have made substantial progress in working on our waiting times problem since the GAO did their study several years ago. The Veterans Health Administration (VHA), in collaboration with the Institute for Health Care Improvement (IHI), developed a model for large system change that is resulting in significant access improvement. This Advanced Clinic Access (ACA) initiative is oriented to meeting the demand of its patient population for care at the time the request is made.

VA has been faced with increased demand and increased Congressional and public scrutiny related to waiting times. In July 2002, VA found itself in the untenable situation of having over 300,000 veterans who were not able to get an appointment within 6 months of their desired date. Substantial efforts have been made to remove patients from the wait list. However, for every 100 veterans we remove, an additional 95 veterans are added to the wait list. By utilizing the key components of our Advanced Clinic Access initiative, clinics are able to make office practice efficiencies that ultimately result in increased capacity. Only when a clinic has made all of the identified efficiencies can one truly justify increased resources. With ACA, providers can now provide the necessary data for addressing the resource issue. However, implementing ACA requires time, patience, leadership support and culture change.

VHA developed an electronic wait list (EWL) that facilities are using as a management tool to track veterans who are waiting for an appointment to be scheduled. The (EWL) software allows VHA to uniformly record veterans awaiting appointments in VistA to more consistently and accurately reflect demand across VHA. This software integrates with the existing VistA scheduling software at each site to allow placement of veterans on waiting lists as part of the automated scheduling process when appointments are not available in the desired timeframe. This software is in full use across the VA medical centers. Additional software was released to allow this information to be rolled up from the medical centers into a national database located at the Austin Automation Center. National reports will provide information about the number of patients waiting for specific types of care at VA facilities and the length of time that they have been on the wait list.

To ensure that VISNs implement the IHI reforms, VHA developed an infrastructure to sustain improvement gained from ACA implementation and to facilitate the spread of ACA across the VHA system. The infrastructure includes the following:

—An Advanced Clinic Access Steering Committee, chaired by a VISN director, and charged with oversight of ACA implementation, is in its third year of operation.

—The steering committee appointed liaisons to each of the six performance measure clinics. These liaisons have established regular conference calls to accelerate the spread of ACA. Attendance at these calls ranges from 50 to 100 clinicians per call.
—VHA has developed a network of ACA coaches/experts who have implemented ACA in their own clinics and are willing and able to teach others. Four meetings of ACA coaches, designed to further the development of these coaches and to develop additional coaches, have been held over the last three years. Regional conferences across the country are planned for the fall of 2003. The goal is to double the number of ACA coaches over the next 18 months.
—Additionally, VHA has established ACA Points of Contact in each VISN and each facility. Each VISN has developed a plan for implementation of ACA.
—In October 2002, VHA appointed a full-time Clinical Program Manager to continue the work begun by IHI and provide coordination and oversight of the implementation of ACA across all of its clinics.

Oversight of ACA implementation is accomplished through regular review of the data related to waiting times, daily communication between the VHA program manager and the field, and articulation of the importance of ACA implementation by VHA senior leaders. A handbook outlining the ACA principles and implementation strategies will be published this spring.

PRESCRIPTION DRUGS

Question. We have heard that a significant number of veterans on the waiting list are coming to VA simply to have their privately written prescriptions filled because VA provides a generous prescription drug benefit. In its December 20, 2000 report, the IG recommended increasing the pharmacy copay from $7 to $10 and streamlining the current VA process of filling prescriptions written by private physicians. The IG estimated that VA's administrative costs for re-writing prescriptions obtained from private healthcare providers was $1.3 billion in fiscal year 2001.

Are there ways to structure a more streamlined and cost-effective approach so that veterans do not have to wait to have their prescriptions filled?

Answer. VHA has not concurred with the findings of the December 2000 OIG report or the draft update of the report. VHA has met with OIG to review its concerns and, as a result, OIG is currently in the process of recalculating its estimates of cost avoidances.

VA is aware that the lack of Medicare prescription drug coverage is causing some veterans to turn to VA for access to prescription drugs. While VA acknowledges that some veterans have stated that they only want VA to provide drugs and not medical care, data suggest that approximately 25 percent of veterans who have stated that they are seeking VA care primarily for prescription drugs actually end up using other VA services as well, including eye care, cardiology, urology, and, in some cases, inpatient care. Any analysis must also consider the potential for significantly increased demand—an unintended consequence of most proposals.

VA has agreed to work with Congress to find a solution to the vexing problem of waiting lists. VA is currently examining options for prescription drug benefits and, in doing so, is carefully assessing the likely impacts (financial and clinical) of such policies. VA must take care to ensure that the actions taken have no unintended consequences that could adversely affect VA's ability to provide timely, quality health care to enrolled veterans.

Lastly, VA believes that a VA/Medicare + Choice cooperative initiative between VA and the Department of Health and Human Services will be a major step forward in addressing this problem and is looking forward to continuing that project's development.

CARES

Question. First, congratulations on implementing the CARES program in Chicago. I know your decision was difficult but it was the right thing to do. For the rest of the Nation, you are undertaking a very ambitious plan to have all the CARES plans completed by the end of this year. I also appreciate the $225 million in the request to jumpstart CARES in fiscal year 2004.

Do you have any preliminary estimates of the cost-savings you expect to achieve from CARES and how will these savings be re-directed to health care services for veterans?

Answer. The Department estimates approximately $3 billion in net savings over a five-year period, beginning in fiscal year 2006. This estimate was developed via a five-year investment plan, based upon the experience and the data compiled from the completed VISN 12 (Chicago Area) CARES study, and extrapolated to the VA

healthcare system nationwide. While the majority of savings will be from operational efficiencies, some receipts and in-kind consideration may also be generated by VA enhanced-use lease program. The potential sale of excess or underutilized real property may also yield some savings. The redirecting of resources from underutilized facilities to direct patient care will allow VA to better serve veterans.

When the National Cares Plan is completed, potential investment needs and cost savings related to implementing CARES will be revised. The plan will be monitored and updated with each budget submission.

COLLECTIONS

Question. VA projects to collect $524 million more in 2004 compared to 2003 yet its collections efforts continue to have problems. The GAO recently reviewed VA's operations and found that VA has improved its collections but it continues to confront operational problems, such as billing opportunities that limit the amount VA collects. A VA IG report estimated that VA could have collected over $500 million more than it actually did in fiscal years 2000 and 2001. However, due to VA's operational limitations, the GAO reported that VA lacks a reliable estimate of uncollected dollars, and therefore does not have the basis to assess its system-wide operational effectiveness.

How is VA responding to these issues? Will you reach your collections goal for fiscal year 2003? How confident are you in reaching your projected goal of collecting $2.1 billion in fiscal year 2004?

Answer. VA has collected $715 million through March of 2003, which is 95.5 percent of our target collection goal at this point in the fiscal year. We anticipate being very close to our annual collection goal of $1.6 billion by the end of September 2003 given the multitude of program enhancements being put in place. In particular, we are continuing to evaluate and enhance the current VistA system in order to support a pilot commercial billing and collection system in the future. These changes will continue to achieve our collection goals in fiscal year 2004 and future years.

HOMELESSNESS

Question. Last year, with this Committee's support, the Administration reactivated the Interagency Council on Homelessness to improve the coordination of federal homeless programs—most notably between HUD, HHS, and VA. One of the most notable products of the ICH is the recent launching of a new $35 million collaborative program between HUD, HHS, and VA to provide permanent housing, health care, and other services to chronic homeless people.

Can you tell me more about this program and your plans for fiscal year 2004, including the proposed Samaritan program? What are your views about the ICH? Due to the current waiting time problems, are homeless veterans waiting for medical care services?

Answer. As you know, in March I was appointed the Vice Chair of the Interagency Council on Homelessness (ICH). The ICH provides an excellent forum for discussing the problems facing homeless people, including homeless veterans. It also serves as a vehicle for developing the federal strategy to end chronic homelessness in America.

One of the keys to ending chronic homelessness is assuring that homeless people have access to mainstream services such as Medicaid, Food Stamps, Temporary Aid to Needy Families (TANF), and other programs. HHS, HUD and VA are sponsoring State Policy Academies to bring together state leadership teams to identify policies and develop strategic plans to assure that homeless people have better access to health care, mental health care, and support services that can help chronically homeless people exit from homelessness. Eighteen states have sent teams to two Policy Academies on chronic homelessness. We hope to hold three more Policy Academies on chronic homelessness over the next 6 months so that all states will have an opportunity to participate in developing strategies to end chronic homelessness.

The $35 million joint HUD/HHS/VA Initiative is also designed to address the needs of chronically homeless people. Under this initiative, HUD will provide $20 million to support permanent housing, HHS will provide $10 million to support primary care, mental health care, and substance abuse treatment, and VA is providing $5 million to support case management for homeless veterans involved in the funded projects. VA will also support program monitoring and evaluation of all funded projects. Coordinated applications from interested service providers are due by April 14, 2003. The Samaritan Program is expected to be an expansion of the joint HUD/HHS/VA initiative.

Homeless veterans, like all veterans seeking health care from VA are experiencing some problems with waiting times at some VA medical facilities. VA is taking ag-

gressive steps to reduce waiting lists and waiting times for veterans enrolled in VA's health care system. These steps include providing urgent care within 24 hours, providing priority care for veterans who are 50 percent service connected or greater, and initiating procedures to improve scheduling of appointments.

HOMELESS SPENDING

Question. For fiscal year 2004, VA estimates that it will spend almost $1.4 billion for veterans who are homeless and that nearly 90 percent of that spending will come from mainstream services, such as medical care. These funds are not targeted to homeless veterans. This demonstrates that homeless veterans have access to these mainstream services. Research from other kinds of health care systems, however, shows that investment in housing for homeless people, and certainly for chronically homeless people, can more than pay for itself in reductions in the number and length of hospitalizations, not to mention how it improves the lives of the individuals in question.

How is VA responding to the permanent housing needs for chronically homeless veterans, especially those who are frequently in and out of your hospital system?

Answer. Since 1992, VA and HUD have participated in the joint HUD-VA Supported Housing (HUD-VASH) Program in 35 locations. Under the program, homeless veterans have received dedicated Section 8 rental vouchers and VA provides ongoing case management services for homeless veterans who receive the vouchers. HUD has committed 1,753 Section 8 vouchers to this program. Over the course of the past 10 years, 4,400 homeless veterans have had access to these vouchers and have secured permanent housing. The median length of stay for veterans in the HUD-VASH program is 4.1 years. A rigorous long-term follow up of the HUD-VASH Program showed that rental assistance, coupled with case management services, provides a successful treatment strategy to help homeless veterans gain access to permanent housing and receive treatment for medical, mental health, and substance abuse disorders which helps them remain in permanent housing.

VA also has implemented its Supported Housing (SH) Program in 23 locations. Clinicians in the SH Program provide long-term case management services to homeless veterans and help them find and remain in long-term transitional or permanent housing. The difference between the HUD-VASH Program and the SH Program is that veterans in SH do not have access to dedicated Section 8 vouchers, although many veterans in this program secure Section 8 vouchers through traditional procedures. In fiscal year 2002, 1,639 veterans were assisted with housing and were provided clinical case management services. The median length of stay for veterans in the SH Program is about 8 months.

Although not yet operational, it is expected that homeless veterans will have access to permanent housing through the HUD/HHS/VA Initiative and the Samaritan Program.

It is also expected that VA's Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans Program will assist in making funding available to organizations interested in developing long-term transitional housing for homeless veterans. While this is not a permanent housing program, we believe that homeless veterans who can live in long term transitional housing that offers a substance free environment and access to supportive services will have greater opportunities to move on to permanent housing.

CLAIMS PROCESSING

Question. Will you meet your goal of processing in an average of 100 days?

Answer. We are committed to meeting the Secretary's goals for improving the timeliness of disability claims processing. Acting upon recommendations from the VA Claims Processing Task Force, the Under Secretary for Benefits has established specific performance targets for regional offices that are in line with the national goal of processing disability compensation claims in 100 days, on average, by September 2003. In addition, we have implemented changes to our business processes. We are consistently tracking our progress and have seen a steady decline in the average processing days over the past year. Although much progress has been made, achievement of this goal remains our biggest challenge.

Question. By improving the timeliness of claims processing, are you compromising the accuracy?

Answer. VBA has experienced a steady increase in our accuracy rate for rating related actions over the past two years. In March 2001, our accuracy rate for rating related actions was 67 percent. As of March 2002, this rate had increased to 79 percent. Based on our most recent data, from January 2003, our accuracy rate for rating related actions is 83 percent. We have also implemented several measures to

ensure continued improvement in accuracy rates, including implementation of national performance standards for key positions in the Veterans Service Centers.

Question. Are more claims being re-examined because of errors?

Answer. We have not experienced a significant increase in the number of claims re-adjudicated as a result of the correction of errors identified by national or local reviews. We will continue to monitor the cases where errors are found and provide necessary oversight to ensure that the requisite corrections are made expeditiously. In addition to correcting these errors, stations will provide employees with feedback and training, where necessary.

MANDATORY SPENDING FOR HEALTH CARE

Question. What are your views on moving VA health care from discretionary to mandatory funding?

Answer. VA does not support the concept of using a fixed formula to determine VHA funding. Although VA recognizes the appeal of such an approach, particularly in these times when the Department finds it is unable to provide care to all veterans who seek enrollment in the system, we believe the would prove to be unworkable and is inappropriate for funding a dynamic health care system, like VA's.

The provision of care evolves continually to reflect advances in state of the art technologies (including pharmaceuticals) and medical practices. It is very difficult to estimate both the costs and savings that may result from such changes. Moreover, patients' health status, demographics, and usage rates are each subject to distinct trends that are difficult to predict. Using a proposed formula could not take into account any changes in these and other important trends. As such, there is no certainty that the amount of funding dictated by the proposed formula would be adequate to meet the demands that will be placed on VA's health care system in the upcoming years.

Perhaps more importantly, use of an automatic funding mechanism would also diminish the valuable opportunity that members of the Congress and the Executive Branch now have to carry out their responsibility to identify and directly address the health care needs of veterans through the funding process. It might also tend to depress the Department's incentive to improve its operations and be more efficient.

Finally, VA does not believe this proposal would ensure open enrollment. The Department would still be required to make an annual enrollment decision, and that decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula. Indeed, references to "guaranteed funding" may give the public the false impression that this bill would give VA full funding to enroll all veterans and to furnish care for all their needs, which would not be the case.

Question. What impact does this have on Congress' ability to oversee the expenditure and performance of the VA's health care programs?

Answer. VA would be able to provide the same detailed programmatic and cost information to Congress as it does today. However, by shifting VA health-care to a formulaic funding methodology Congress may be inclined to shift its focus away to other discretionary programs.

HEALTH CARE QUALITY MANAGEMENT AND PATIENT SAFETY

Question. What specific actions have been taken in response to the OIG report, Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities (Report No. 02–00266–76, dated March 2002)?

Answer. A number of offices within VHA and the Office of Preparedness formed a joint work group to address the issues raised in the OIG Report No. 02–00266–76. A number of meetings resulted in specific actions to address this report. VHA has subsequently taken actions to address the recommendations as summarized below.

Security is a standing agenda item for National Radiation Safety Committee (NRSC) meetings. The primary basis to review the status of security issues is the security status report. The report includes information about the strategy for oversight, Office of Inspector General (OIG) report response, site visit results, source disposals, and information dissemination.

The NRSC actions or strategy for security include having a standing agenda item for NRSC committee meetings, monitoring the National Health Physics Program (NHPP) focus on security, responding to OIG, NRC, and other initiatives, and evaluating changes for the handbook/directive.

The NHPP actions or strategy for security include having a focus on security during inspections/site visits, providing updates to the security status report, providing information to the medical centers, preparing changes for the handbook/directive, evaluating disposal options for sources, and monitoring regulatory changes.

The medical centers actions or strategy for security include increasing VA Police Service coordination, reviewing their radiation safety footprint at least annually, maintaining security of radioactive materials and/or radiation sources, and implementing the VHA Directive 2002–075, "Control of Hazardous Materials in VA Research Laboratories."

VHA Directive 2002–075, which directly addressed seven of the OIG recommendations, codified and clarified existing procedures and also complied with requirements mandated in the USA Patriot Act of 2001. The directive, which includes over 18 pages of detailed instructions to VA medical centers (VAMC) to specifically address the OIG report, has been discussed with all the VAMCs through conference calls as well as informal discussions with those in leadership positions at the VAMCs charged with implementing the recommendations. In addition, all sites with research programs have been notified about the impact of the USA Patriot Act of 2001. VHA and VA's Office of Policy, Planning and Preparedness have jointly signed a letter to all VHA facilities outlining additional controls necessary to control the access to these agents.

VHA conducts annual work place evaluations for safety of all VHA facilities and increased security and compliance with VA and Joint Commission on Accreditation of Health Care Organizations (JCAHO) emergency management activities are getting increasing scrutiny. JCAHO in their accreditation surveys are also emphasizing emergency management plans and programs necessary to meet their standards.

VHA has also begun a comprehensive assessment of the potential vulnerabilities of VA BSL 3 laboratories. Medical facilities have received a security self-assessment checklist for BSL 3 sites, and completed a self-assessment that all items on the checklist have or will be completed. In calendar year 2003 VHA will begin announced and unannounced inspections of sites with BSL 3 laboratories to ensure compliance with the checklist and the directive. VHA will suspend operations in BSL 3 laboratories that cannot demonstrate an appropriate level of security will be maintained.

An Emergency Management Program Guidebook has also been developed and provided to each VAMC to improve their emergency management programs to meet VHA and JCAHO standards for emergency management. This guidebook provides sample policies procedures and best practices for emergency management including the VAMC from potential terrorist threats and events as well as research and clinical laboratories.

VHA has initiated a program to spend more than $2 million to upgrade laboratory security at more than 50 sites in February 2002, and that office will systematically review all research sites over the next 3 years as part of its infrastructure program to identify and fund equipment needs that include security devices. Thirty-eight sites have received or been approved for funding. VHA will review the revised applications from another 26 sites in fiscal year 2003.

Question. Is there funding in the fiscal year 2004 budget request to cover the full cost to implement controls and make necessary changes?

Answer. We believe that the fiscal year 2004 budget request contains sufficient funding. A survey conducted within VHA documented that approximately $13 million was spent in the last year for security enhancements, including security of laboratories. Individual projects to implement all of the requirements mentioned above that are beyond the resources of individual VA medical centers will have to be requested as part of VHA's capital resources process and compete with other patient care infrastructure initiatives.

QUESTIONS SUBMITTED BY SENATOR CONRAD BURNS

Question. Many in Montana Veterans have significant trouble getting in to see doctors due to scheduling backlogs. Does the VA budget compensate to enable faster processing, in order to meet this demand? If so how?

Answer. Yes, the 2004 budget proposes to reduce the average waiting time for new patients seeking primary care clinic appointments to 30 days in 2004 and reduce the average waiting time for next available appointment in specialty clinics to 30 days in 2004. VA is working to improve access to clinic appointments and timeliness of service. VA continues efforts to develop ways to reduce waiting times for appointments in primary and specialty care clinics. By refocusing VA's health care sys-

tem on these groups, VA will be positioned to achieve our primary and specialty care access standards.

Question. The VA claims process currently takes 9 to 12 months to file claims, and 9 to 11 months for remands. Does the VA budget provide for the resources necessary in order to expedite the claims processing process?

Answer. Budget authority of $621.4 million and 6,816 FTE (without OBRA) are requested to fund the discretionary portion of the Compensation program in 2004. Compared to the 2003 current estimate, budget authority is expected to show a net increase of $15.0 million.

Budget authority of $151.7 million and 1,635 FTE (without OBRA) are requested to fund the discretionary portion of the Pension program in 2004. Compared to the 2003 current estimate, budget authority is expected to decrease by $2.4 million.

We believe the reorganization of service centers into specialized work teams, as prescribed by the Claims Processing Task Force report, will increase work efficiencies in the Compensation program. Based on workflow analysis, VBA believes the discretionary portion of the compensation program budget will be sufficient.

While the discretionary portion of the pension program budget shows a decrease, we believe that the consolidation of pension workload in the Pension Maintenance Centers will lead to a gain in workflow efficiencies. Therefore, the reduction in this area should not negatively affect the pension claims process.

Question. Many veterans that need hospitalization sometimes have a problem traveling long distances, and not all patients are reimbursed for their travel expenses. Does the VA budget compensate for providing veterans that need hospitalization transportation to the hospital?

Answer. Yes, VA's budget includes compensating certain veterans for hospital transportation to and from a department facility, but only if they meet the eligibility requirements set forth under current law. In accordance with 38 U.S.C. § 111(b)(1), VA is authorized to reimburse the following category of veterans for their travel:

—veterans or other persons whose travel is in connection with treatment or care for a service-connected disability;
—veterans with a service-connected disability rated at 30 percent or more;
—veterans receiving pension under section 1521 of title 38 USC;
—veterans whose annual income does not exceed the maximum annual rate of VA's pension;
—a veteran or other person who is required to travel by special mode and who is unable to defray the expenses of travel; and
—a veteran whose travel to a Department facility is incident to a scheduled compensation and pension examination.

Question. Does the budget compensate for reimbursing all patients for their travel? If so, how?

Answer. VA is not authorized to reimburse all patients for their travel. VA may only authorize travel reimbursement for those veterans who meet the eligibility requirements under 38 U.S.C. § 111(b)(1). For those veterans who are determined to be eligible, reimbursement may be authorized based on mileage allowance or common carrier, whichever is less. If mileage reimbursement is authorized, a veteran is reimbursed at the rate of 11 cents per mile and is subject to a $3.00 deductible for each one-way visit and a $6.00 deductible for each round-trip visit. The deductible is capped at an $18 monthly deductible.

Additionally, when a clinical determination is made that special mode transportation is required, VA may also authorize a veteran to be transported by ambulance services or by other modes of special mode transportation. However, in these cases, a determination must be made by VA that the veteran is unable to defray the expenses of travel.

Question. Does the VA budget allow for additional clinics in rural areas? If so, what are the plans for these new facilities?

Answer. Decisions on new Community-Based Outpatient Clinics will be made on a case-by-case review until the CARES study is completed.

QUESTIONS SUBMITTED BY SENATOR PETE V. DOMENICI

COMMUNITY-BASED OUTPATIENT CLINICS

Question. Mr. Secretary, I am pleased with the 7.5 percent increase that President Bush has proposed for the Department of Veterans Affairs budget for fiscal year 2004. This kind of investment allows us to keep our commitments to America's veterans and I look forward to working with you to implement this budget.

Of course, challenges remain and I am committed to addressing them, as well. One of those challenges concerns the stability of Community-Based Outpatient Clinics.

Last year, veterans in southeastern New Mexico notified me that Artesia Clinic was not accepting new patients because there were not enough doctors to accommodate the caseload.

Although, the delay in service was only temporary, it was a cause of anxiety for many veterans. I am concerned about this because so many of New Mexico's veterans rely on clinics for their outpatient needs.

I wrote to you about my concerns and in your response you noted that actual increases in the use of VA health care systems had outpaced projections.

As we work together to find a solution to this problem, to what should we attribute the backlog of patient caseload in the VA health system? Is it a matter of more veterans needing care? Is it a shortage of medical staff? Is it a lack of funds? If it is a combination of these factors, what approach do you recommend to alleviate the problem?

Answer. Public Law 104–262, the Veterans Health Care Eligibility Reform Act of 1996, mandated the VA to establish and implement a national enrollment system to manage the delivery of healthcare services to veterans. This legislation led the way for the creation of a Medical Benefits Package to provide a standard health plan for all veterans. Enactment of this legislation opened up the VA health care system to all veterans and generated a significant increase in VA enrollees and patient users. This has precipitated serious problems with access to VA outpatient care. In addition to the increased demand, VA has also been faced with pockets of nursing shortages and problems in recruiting physicians to the VA system. We have many initiatives to address some of these problems such as the physician pay bill, hiring of retired annuitants, recruitment and retention bonuses, incentive pay, and specialty pay schedules. So the answer to your question is that it is a combination of many factors.

To ensure that VISNs implement clinic management efficiencies as part of our Advanced Clinic Access (ACA) initiative, VHA developed an infrastructure to sustain improvement gained from ACA implementation and to facilitate the spread of ACA across the VHA system. The infrastructure includes the following:

—An Advanced Clinic Access Steering Committee, chaired by a VISN director, and charged with oversight of ACA implementation, is in its third year of operation.

—The steering committee appointed liaisons to each of the six performance measure clinics. These liaisons have established regular conference calls to accelerate the spread of ACA. Attendance at these calls ranges from 50 to 100 clinicians per call.

—VHA has developed a network of ACA coaches/experts who have implemented ACA in their own clinics and are willing and able to teach others. Four meetings of ACA coaches, designed to further the development of these coaches and to develop additional coaches, have been held over the last three years. Regional conferences across the country are planned for the fall of 2003. The goal is to double the number of ACA coaches over the next 18 months.

—Additionally, VHA has established ACA Points of Contact in each VISN and each facility. Each VISN has developed a plan for implementation of ACA.

—In October 2002, VHA appointed a full-time Clinical Program Manager to continue the work begun by IHI and provide coordination and oversight of the implementation of ACA across all of its clinics.

In addition to our Advanced Clinic Access initiative that assists clinics in making office practice efficiencies, we monitor through the network performance plan the following key indicators for access to care:

Measure: Waiting Times—Clinic

By September 30, 2003, networks will improve waiting time for key clinics as measured by a combination of indicators to include:

—a. *Primary Care—New Patients.*—Percent of new patents at 3rd Qtr of the SHEP Survey who answer "yes" to the question, "Did you get an appointment when you wanted one?" Target—79 percent.

—b. *Primary Care—Established Patients.*—Percent of established patents at 3rd Qtr of the SHEP Survey who answer "yes" to the question, "Did you get an appointment when you wanted one?" Target 79 percent.

—c. *Specialty Care.*—Wait time from date entered into scheduling package until date of appointment for "Next Available Appointment", in September 2003 for patients in (all individual targets must be met):

—i. *Eye care.*—Target 63 days or less.

—ii. *Urology.*—Target 44 days or less.
—iii. *Orthopedics.*—Target 43 days or less.
—iv. *Audiology.*—Target 40 days or less.
—v. *Cardiology.*—Target 42 days or less.

In July of last year, all networks submitted plans for reducing their backlog in anticipation of supplemental dollars. Because of the continuing resolution, many of these plans were placed on hold. Now that we have a budget, networks are working on implementing those plans such as recruiting and hiring providers or contracting for scarce services and buying equipment.

We developed an electronic wait list that serves as a management tool for monitoring those veterans who have yet to be scheduled for an appointment. We routinely provide reports and monitor the progress being made in removing patients from the wait list.

Non-acceptance of new patients into the New Mexico Healthcare System's Artesia CBOC was a temporary situation caused by a lack of physician staffing. However, the issue has now been resolved. Beginning January 2003, new patients are being accepted into the Artesia CBOC for care. Patients with a 50 percent or greater service-connected disability have priority for appointments.

The current staffing level at the Artesia CBOC is able to provide care to 2,400 veterans and currently has 2,100 veterans enrolled. When an eligible veteran applies for care at the Artesia CBOC, the veteran is provided a New Patient Health Questionnaire. Following the completion and return of the questionnaire, the veteran is scheduled for a new patient appointment. On-going care for the veterans in southeastern New Mexico will remain a priority.

CLAIMS PROCESSING

Question. Is there something the VA can do to process claims more efficiently?

Answer. The Claims Processing Task Force examined a wide range of issues affecting the processing of claims, from medical examinations and information technology to efforts to shrink the backlog and increase the accuracy of decisions. Numerous countermeasures were implemented to address the issue of the growing backlog. At the beginning of 2002, over 432,000 cases were pending rating action, 47 percent of which were over six months old. As of March 14, 2003, the number of cases pending rating action had been reduced to just over 310,000, with approximately 29 percent pending over six months. We continue to strive toward the Secretary's goal of 100 days average processing time and reduction of our claims inventory to 250,000 by the end of fiscal year 2003.

Question. Is there merit in the idea of calling on veterans' organization to help process claims on a voluntary basis?

Answer. While the ultimate responsibility for claims processing rests with the Veterans Benefits Administration (VBA), the assistance provided by veterans service organizations (VSOs) is extremely valuable in timely processing of claims. To improve the relationship that already existed, a partnership between VBA and VSOs was formed through the Training Responsibility Involvement and Preparation (TRIP) initiative to enhance service to claimants by combining resources and focusing on shared concerns. The vision of the TRIP initiative is to improve the claims adjudication process by:

—reducing duplication of effort and combining resources,
—providing a more direct focus on claims preparation,
—placing a stronger emphasis on front-end of claims processing,
—improving the quality of claims submission, and
—improving timeliness of claims processing.

We have recently expanded TRIP training to include a Train-The-Trainer program. This program is a course of instruction on how to teach the TRIP program given to a service officer who has already completed the training. This is particularly beneficial to VSOs with out-based employees and helps to reduce travel expenses incurred in TRIP training. We have conducted successful Train-The-Trainer programs in Delaware, Florida, Alabama, and the District of Columbia. Other sessions are planned soon in Washington and in California.

There are legal issues involved in having VSOs help process claims on a voluntary basis. The VA General Counsel would have to consider these before the concept could be taken into consideration.

HOMELESS VETERANS

Question. I am concerned about the growing number of homeless veterans in my state. Many suffer with mental health conditions and substance addictions. Unfortunately, many are reluctant to seek assistance from the VA.

How does the VA budget request for fiscal year 2004 address the problem of homelessness among veterans? Does the VA approach to homelessness pro-actively seek out those veterans who need assistance?

Answer. Approximately $174 million of VA's proposed fiscal year 2004 medical care budget is specifically targeted for specialized services for homeless veterans. Over the last 16 years, VA has developed the largest integrated national network of services for homeless people in the country. Components of VA's continuum of care include:

—aggressive outreach to homeless veterans living on the streets or in emergency shelters;
—clinical assessment to determine treatment needs;
—linkage to VA medical center programs for medical, mental health, and substance abuse treatment;
—case management services;
—residential rehabilitation in VA's Domiciliary Care for Homeless Veterans (DCHV) programs and Transitional Residence Programs for veterans in Compensated Work Therapy (CWT) Program and supported, community-based housing through VA's Grant and Per Diem Program;
—assistance with employment through VA's CWT Program; and
—assistance with permanent housing.

Outreach to homeless veterans is an integral component of VA's continuum of care for homeless veterans. In fiscal year 2002, approximately 370 VA staff were dedicated to outreach and case management services for homeless veterans. These VA clinicians contacted almost 43,000 homeless veterans through outreach.

Question. Does the VA plan to incorporate a continuum of care for veterans with mental illness that includes availability and accessibility to physician services, state of the art medications, supported housing and integrated substance abuse treatment?

Answer. VA has been in the forefront in providing a full continuum of care for veterans requiring mental health services. The VHA Policy Manual (M–2, Part X, Chapter 3, June 29, 1993) describes a fully integrated psychiatric continuum of mental health including physician services, state of the art medications, supported housing, and integrated substance abuse treatment. This was followed by a VHA Program Guide 1103.3, Mental Health Program Guidelines for the New Veterans Health Administration, published June 23, 1999. This guidance expands on the manual, incorporates elements from the Eligibility Reform Act of 1996, includes the evidence base for our programs, and describes in more detail the continuum of care for special populations. These special populations include veterans with a serious mental illness, those with substance use disorders including dually diagnosed patients, those with post-traumatic stress disorders, homeless mentally ill veterans, elderly veterans with psychogeriatric problems, veterans in rural areas, and special considerations for women and other minority veterans. It includes principles involving integration of mental health and primary care management, and psychosocial rehabilitation including an integrated work rehabilitation program.

The issue of availability and accessibility to mental health services involves how the VHA budget is distributed among our many facilities and clinics through the Veterans Equitable Resource Allocation (VERA) system and how decisions are made at the Veterans Integrated Services Network (VISN) level and at each medical center or health care system. VHA policy is to provide equitable access to funding and clinical care for veterans with a mental disorder as compared to those with all other disorders. The final decision generally rests at the facility level where local needs and priorities can be balanced for all veterans seeking care.

ANTIPSYCHOTIC DRUG ZYREXA

Question. Mr. Secretary, on March 4, 2003, USA Today reported that Eli Lilly is facing multiple lawsuits over the antipsychotic drug Zyprexa (olanzapine) for deadly diabetic conditions caused by the drug. Many veterans are prescribed Zyprexa to treat their mental illness. Consequently, many veterans have been or will be exposed to the same diabetes risks that are the subject of these new lawsuits.

What is the VA doing to address the side effect risks posed to veterans who are prescribed Zyprexa? Has the VA studied the effects of Zyprexa on veterans at risk of developing diabetes? Has the VA considered what, if any, potential liability it may incur to veterans who develop diabetes as a result of Zyprexa treatment received at the VA?

Answer. I'm pleased to report that VA was one of the first large managed care organizations in the United States to address the issue of weight gain and diabetes associated with the atypical antipsychotic drug class at the enterprise level. In Au-

gust 2001, in cooperation with the VA Mental Health Strategic Health Care Group, the VA Medical Advisory Panel and Pharmacy Benefits Management Strategic Health Care group developed and published guidance to VA practitioners regarding the relative safety and cost of the atypical antipsychotics available on the VA National Formulary. The published medical literature is continuously monitored for emerging data and when appropriate, the guidance is updated. Most recently guidance was updated in June 2002.

In addition, VA is in the process of updating its Schizophrenia Clinical Practice Guideline and will include all available and relevant information regarding the known risks associated with this class of drugs.

Finally, the VA Pharmacy Benefits Management Strategic Health Care Group and Medical Advisory Panel are currently working with the United States Food and Drug Administration (FDA) on a quality improvement and appropriateness of use analysis of the atypical antipsychotic drug class in veteran patients. It is expected that a joint report will be issued before the end of calendar year 2003.

QUESTIONS SUBMITTED BY SENATOR BARBARA A. MIKULSKI

PRIORITY 7 AND 8 VETERANS

Question. VA recently announced that Priority 8 veterans can no longer enroll in the VA medical care system. I understand this decision to mean that Priority 8 veterans coming to VA for the first time will not be able to enroll, but that Priority 8 veterans who are already in the system will be "grandfathered-in." Is this correct?

Answer. That is correct; veterans enrolled in Priority Group 8 on January 16, 2003, remain enrolled and eligible for VA health care benefits. Veterans applying for enrollment on or after January 17, 2003, whose financial status places them in Priority Group 8, are ineligible for care. An exception is that veterans with service-connected conditions rated zero percent disabling may seek care for their service-connected condition(s).

Question. Is this decision temporary, or permanent? Does VA's 2004 budget continue this policy?

Answer. The Secretary is required to assess veteran demand and availability of resources and make an enrollment decision on an annual basis. The decision to restrict enrollment of Priority Group 8 veterans will be reconsidered during this annual process. The VA 2004 budget request continues the policy of restricting enrollment of Priority Group 8 veterans.

Question. Can you please explain VA's authority to make this decision?

Answer. The bases for VA's patient enrollment system are found in 38 U.S.C. § 1705 and 38 C.F.R. 17.36 through 17.38. Section 17.36(c) of title 38 C.F.R. specifically delineates the Secretary's need to review estimates of veteran demand and all available resources and to make an annual enrollment decision.

Question. VA tells us that the number of Priority 7 and 8 veterans in the VA system is skyrocketing. Do you think this is because of VA's prescription drug benefit?

Answer. The number of Priority Group 7 and 8 veterans treated in 2002 was about 11 times greater than in 1996. The combined effect of several factors that resulted in this large increase in demand has severely strained VA's ability to continue to provide timely, high-quality health care. First, the Veterans Health Care Eligibility Reform Act and the Millennium Health Care Act opened the door to comprehensive health care services to all veterans. Second, access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics. Third, our patient population is growing older and this had led to an increase in veterans' need for health care. Fourth, VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our health care system.

However, VHA's actual experience in fiscal year 2002 shows that of the 2,129,317 Priority 7 enrollees, approximately 50 percent were users. Of those 1,075,040 users, 63 percent had three or more encounters, which indicates a reliance on VHA for health care in addition to pharmacy. In addition, VA analyzed the actual utilization of newly enrolled veterans who indicated in the VHA New Enrollee Survey that their primary reason for VA enrollment was pharmacy access. These enrollees experienced 3.4 visits per patient and 4.5 clinic stops per patient and the services used were not limited to primary care and pharmacy. Twenty-five percent of the non-ancillary encounters were to specialty clinics, such as eye care, cardiology and urology and in fact, some of the patients had inpatient admissions. This indicates that although a pharmacy benefit was stated as the primary reason for enrollment, these enrollees use other VA services as well.

Question. Do you think that VA is faced with absorbing this new demand because of a lack of national policies to address the aging of America and the collapse of many HMOs?

Answer. Public disenchantment with health maintenance organizations, along with their economic failure, may have played a role in causing many patients to seek out established and traditional sources of health care such as VA. However, we believe that VA is faced with this new demand primarily because of our strength as a comprehensive health care system and because we so ably provide our veteran patients with a complete and comprehensive continuum of care in a coordinated and unified healthcare system, which includes a prescription drug benefit. More than half of those veterans who receive health care through VA are over age 65. VA patients are not only older in comparison to the general population, but they generally have lower incomes, lack health insurance, and are much more likely to be disabled and unable to work.

The projected peak in the number of elderly veterans during the first decade of this century will occur approximately 20 years in advance of that in the general U.S. population. Thus the current demographics of the veteran population are one of the major driving forces in the design of the VA health care system into a comprehensive system centered on providing complete continuum of care in a coordinated and unified system.

Question. In December 2000, the VA's Inspector General reported on the use of VA's prescription benefit by Priority 7 veterans. The IG studied a sample group of Priority 7 veterans and found that almost 90 percent either had access to private non-VA health care and/or said that their only reason for using VA was to have their private prescriptions filled. The IG recommended a change in the law so that veterans could have privately written prescriptions filled at the VA. The IG said this could save VA over $1 billion per year. Has the VA looked at this recommendation? How would this idea affect VA? Could VA do something like this on a pilot basis to see if it would work?

Answer. VHA has not concurred with the findings of the December 2000 OIG report or the draft update of the report. VHA has met with OIG to review its concerns and, as a result, OIG is currently in the process of recalculating its estimates of cost avoidances.

VA is aware that the lack of Medicare prescription drug coverage is causing some veterans to turn to VA for access to prescription drugs. While VA acknowledges that some veterans have stated that they only want VA to provide drugs and not medical care, data suggest that approximately 25 percent of veterans who have stated that they are seeking VA care primarily for prescription drugs actually end up using other VA services as well, including eye care, cardiology, urology, and, in some cases, inpatient care. Any analysis must also consider the potential for significantly increased demand—an unintended consequence of most proposals.

VA has agreed to work with Congress to find a solution to the vexing problem of waiting lists. VA is currently examining options for prescription drug benefits and, in doing so, is carefully assessing the likely impacts (financial and clinical) of such policies. VA must take care to ensure that the actions taken have no unintended consequences that could adversely affect VA's ability to provide timely, quality health care to enrolled veterans.

Lastly, VA believes that a VA/Medicare+Choice cooperative initiative between VA and the Department of Health and Human Services will be a major step forward in addressing this problem and is looking forward to continuing that project's development.

Question. Does VA know how many Priority 7 and 8 veterans have other health insurance?

Answer. The following chart shows the insurance coverage for non-compensable, zero percent service-connected (SC) and non-service-connected (NSC) enrollees in Priorities 7 and 8 according to the 2002 VHA Survey of Veteran Enrollees:

PERCENT OF ENROLLEES WITH VARIOUS TYPES OF INSURANCE COVERAGE [1]

Priority	Medicare A	Medicare B	Medigap [2]	Private [3]		Medicaid	TRICARE for Life	No Coverage
				HMO	Non HMO			
P7 SC	65	58	39	12	15	6	11	16
P7 NSC	71	67	47	13	16	8	4	13
P8 SC	54	51	35	18	24	4	22	10
P8 NSC	59	55	42	18	23	4	7	10

Source: 2002 VHA Survey of Veteran Enrollees' Health and Reliance Upon VA.

[1] Percentages do not total to 100 because enrollees may have multiple coverage.
[2] Or Medicare supplemental plan.
[3] Individual or group, excluding Medigap or Medicare supplemental plan.

Question. Are veterans required to tell the VA if they have other health insurance?

Answer. Veterans are not presently required to tell VA if they have other health insurance. However, VA does presently request that veterans voluntarily provide health insurance information on the Application for Health Benefits. Section 112 of Title I of Division K of Public Law 108–7, signed February 20, 2003, prohibits the use of appropriated funds for hospitalization or treatment of certain non-service connected veterans who do not disclose to VA their current health insurance information. Implementing regulations have not yet been issued.

Question. The VA-HUD Subcommittee gave VA $1.1 billion more than the request in 2003, but VA still closed its doors to new Priority 8 veterans. What is VA doing to ensure accuracy in its budgets?

Answer. VA's ability to estimate veteran demand and expenditures has improved significantly with the use of an actuarial health care demand model. This model is based on private sector benchmarks adjusted for our veterans' age, gender, morbidity, utilization, reliance, and insurance. The model projects veteran enrollment, utilization, and expenditures, and provides detailed projections for approximately 50 health care service categories.

While this change to using actuarial projections in budget development now allows us to provide very accurate estimates of expected enrollment and expenditures, it also quantifies the escalating demand for veteran health care. It was clear that continued workload growth of the magnitude experienced in recent years is unsustainable in the current federal budget climate. Therefore, using the model, we developed health care policies designed to ensure that VA is able to fulfill its core mission—providing timely access to high quality health care to veterans with service connected disabilities, low incomes, and those with special needs.

VA expects to provide health care to 3.6 million patients in core Priorities 1–6 in fiscal year 2004, an increase of 5 percent over fiscal year 2003. Priorities 1–6 alone are expected to cost $9 billion more by fiscal year 2008 (over fiscal year 2003).

Question. The budget says that VA will come forward with a new "VA + Choice" program for Priority 8 veterans who can't enroll in VA. How will this happen? Will VA do this by regulation, or does it require authorizing legislation? What are the details of this plan? Will veterans in this program get a prescription drug benefit?

Answer. With the assistance of the Department of Health and Human Services, VA is moving toward implementation of a plan to offer to Medicare-eligible veterans unable to enroll for VA health care the option of using their Medicare benefit to obtain health care through VA. VA plans to accomplish this by contracting with existing Medicare + Choice organizations to offer a special Medicare + Choice plan, which would be called VA + Choice; with the stipulation that VA would define the benefits under VA + Choice, and enrollees in VA + Choice would be able to receive Medicare benefits through VA facilities. The intention is to offer a benefit package that is competitive with those currently offered by M + C organizations and to include some type of additional benefit for prescription drugs.

VA plans for the new VA + Choice plan to begin accepting enrollees by October 2003, and projects an initial demand of 25,000 enrollees within the first year. Medicare eligible Priority 8 veterans who are unable to enroll for VA health care would be offered the option of receiving their Medicare benefits through VA + Choice. The veteran's spouse or other Medicare eligible beneficiaries of the veteran would not be enrolled in the VA + Choice plan but would be able to enroll in a traditional Medicare + Choice plan, including one offered by the M + C organization offering a VA + Choice plan in their area.

$250 ENROLLMENT FEE

Question. How did VA choose $250 as the amount for this annual premium?

Answer. The proposed policies in VA's fiscal year 2004 President's budget were designed to ensure that VA is able to fulfill its core mission—providing timely access to high-quality health care to veterans with serviced connected disabilities, low incomes, and those with special needs.

This fee is similar to the fee charged a military retiree who has devoted 20 years or more of his life to uniform—enlisted or officer. The military retiree who enrolls in the DOD Tricare Prime program has to pay $256 or $456 to receive health care after having served 20 years in uniform. VA tried to structure a proposal with a very small premium for veterans with relatively higher incomes who may have only served 1–4 years in uniform.

The $250 enrollment fee and other cost-sharing proposals would only affect higher income, better-insured veterans in the lowest priorities and have been strategically priced to refocus the VA system on those veterans who need us most. Veterans in Priority 8 and non-service-connected veterans in Priority 7 are being asked to pay more towards the cost of their care, while at the same time, we propose eliminating prescription copayments for the lowest income veterans in Priority 5 by raising the income threshold to the non-service-connected pension and aid and attendance level.

According to data from the 2002 VHA Survey of Veteran Enrollees, 90 percent of Priority 8 enrollees and 87 percent of Priority 7 enrollees have some type of public or private health care coverage (compared to just 70 percent for Priority 5 and 73 percent for Priority 1 enrollees). These policies discourage use of VA by veterans who, for the most part, do not use VA as their primary provider of care but supplement their other care options with services from VA when it is financially opportune for them. Under the proposed policies, these veterans who choose to use VA selectively, such as those who come to us only for prescriptions, can make the economic decision to continue to do so. Most importantly, those veterans who do not have other health care options can still access the high quality, comprehensive care VA provides at a very minimal cost.

Question. What authority does VA have to require this $250 premium? Can VA do this through regulation, or does it require a specific change to the authorizing statutes?

Answer. VA is requesting legislation that would authorize the Secretary to collect an enrollment fee of $250 per year from all veterans enrolling in Priority Group 8 and from all non-service-connected veterans enrolling in Priority Group 7.

Question. How many veterans will have to pay this premium?

Answer. In fiscal year 2004, 1,082,335 Priority 8 enrollees and non-service-connected Priority 7 enrollees are expected to choose to pay the $250 enrollment fee.

Question. How many veterans will leave VA if they have to pay this premium?

Answer. In fiscal year 2004, 1,136,225 Priority 8 enrollees and non-service-connected Priority 7 enrollees are not expected to pay the $250 enrollment fee.

Question. How will VA collect this fee? Will VA send a bill to every middle-income veteran on its list?

Answer. VA proposes to initiate bills at the beginning of each fiscal year for all enrolled veterans required to pay the fee. Bills for existing enrollees would be generated by each veteran's preferred facility. As new veterans subject to payment of the enrollment fee are enrolled, they would be billed at the time of enrollment. After appropriate due process, veterans failing to pay the enrollment fee would be disenrolled.

Question. Some veterans are "enrolled" but they don't use the VA system. They're reserving their space in case their private insurance fails. Will these veterans have to pay $250 even if they don't come to VA yet? How many veterans are like them?

Answer. Enrollees must pay the $250 enrollment fee at the beginning of fiscal year 2004 to remain enrolled and eligible for care in VA. In fiscal year 2002 the number of enrollees in Priority 8 and the non-service-connected enrollees in Priority 7 who did not use the VA system totaled 1,054,277. We expect that 65 percent of those under age 65 and 90 percent of those over age 65 will not pay the $250 enrollment fee.

COPAYMENT INCREASES

Question. How did VA choose $15 as the amount for prescription drugs?

Answer. This and the other proposed policies in VA's fiscal year 2004 President's budget were designed to ensure that VA is able to fulfill its core mission—providing timely access to high-quality health care to veterans with serviced connected disabilities, low incomes, and those with special needs.

The $15 outpatient pharmacy copayment proposal and other cost-sharing proposals would only affect higher income, better-insured veterans in the lowest priorities and have been strategically priced to refocus the VA system on those veterans who need us most. Veterans in Priority 8 and non-service-connected veterans in Priority 7 are being asked to pay more towards the cost of their care, while at the same time, we propose eliminating prescription copayments for the lowest income veterans in Priority 5 by raising the income threshold to the Pension and Aid and Attendance level.

These policies discourage use of VA by veterans who, for the most part, do not use VA as their primary provider of care but supplement their other care options with services from VA when it is financially opportune for them. Under the proposed policies, these veterans who choose to use VA selectively, such as those who come to us only for prescriptions, can make the economic decision to continue to do so. Most importantly, those veterans who do not have other health care options can still access the high quality, comprehensive care VA provides at a very minimal cost.

Question. Can VA increase the prescription drug copayment by regulation, or does VA need authorizing legislation?

Answer. The Secretary has the authority to increase the medication copayment at any time, and this has been specified in the current regulations. Any increase to the medication copayment would need to be put forth in new regulations. The medication copayment amount is based upon VA costs and does not include the cost of the medication. The current VA costs do not support an increase to $15 for the medication copayment. A legislative change will be required to remove the phrase from the current law that states the medication copayment is based on VA costs.

Question. How did VA choose $20 per outpatient primary care visit?

Answer. This and the other proposed policies in VA's fiscal year 2004 President's Budget were designed to ensure that VA is able to fulfill its core mission—providing timely access to high quality health care to veterans with serviced connected disabilities, low incomes, and those with special needs.

The $20 outpatient copayment proposal and other cost-sharing proposals would only affect higher income, better-insured veterans in the lowest priorities and have been strategically priced to refocus the VA system on those veterans who need us most. Veterans in Priority 8 and non-service-connected veterans in Priority 7 are being asked to pay more towards the cost of their care, while at the same time, we propose eliminating prescription copayments for the lowest income veterans in Priority 5 by raising the income threshold to the Pension and Aid and Attendance level.

These policies discourage use of VA by veterans who, for the most part, do not use VA as their primary provider of care but supplement their other care options with services from VA when it is financially opportune for them. Under the proposed policies, these veterans who choose to use VA selectively, such as those who come to us only for prescriptions, can make the economic decision to continue to do so. Most importantly, those veterans who do not have other health care options can still access the high quality, comprehensive care VA provides at a very minimal cost.

Question. Can VA increase the outpatient copayment by regulation, or does VA need authorizing legislation?

Answer. The Secretary has the authority to increase the copayment through a change to VA regulations. Legislation is not required.

COLLECTIONS

Question. How much will VA collect from insurance companies?

Answer. VA estimates that it will collect approximately $760 million in fiscal year 2003 from third-party insurance companies.

Question. Does VA know how much it is owed by insurance companies?

Answer. VA's gross account receivables are $488 million from third-party insurers. Payment is dependent upon the terms of the various policies issued to veterans.

Question. How is VA's collections system set-up?

Answer. VA presently handles collections through a combined effort of employed staff and private vendors who follow-up on accounts once they are delinquent. All staff employ a combination of follow-up letters, phone calls, and other tracking within VISTA computer software to prioritize accounts for follow-up action.

Question. What is VA doing to get better? Is VA seeking help from the private sector to get better?

Answer. VA is putting in place a number of program and operational enhancements with the expectation that they will improve revenue collections by streamlining production of accurate and timely claims. Initiatives include the following:

—*Technology.*—In fiscal year 2002, the Deputy Under Secretary for Health for Operations and Management issued guidance for VHA sites to purchase encod-

ing software. This software enables coders to more accurately and efficiently code encounters and to measure coding productivity. All sites have purchased encoder software.

—*Education.*—VHA is pursuing a variety of educational programs to enhance the knowledge base of coding staff and improve medical record coding. Current educational initiatives include an online web-based coding curriculum, monthly satellite programs on specific coding and documentation topics, and publication of a VHA coding handbook and a quarterly coding newsletter.

—*Documentation and Coding.*—As part of VHA coding improvement efforts, tools have been developed to improve the source documentation created by providers. Many VISN's and VA medical centers have contracted with external vendors to provide coding services as a means to improve lag time in billing and collections. Currently, VHA is pursuing a national coding contract, which will standardize requirements and enhance the quality of the coding provided by vendors.

—*Electronic Claims Submission.*—To streamline VA medical center operations and to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), software for submitting standardized electronic claims and currently, EDI claims software is live at all VA medical centers, and all sites are submitting electronic claims to commercial payers.

VA is also seeking help from the private sector relative to collections including the implementation of a Patient Financial Services System (PFSS) demonstration project that will result in the integration of a commercial billing and accounts receivable system. The primary goal of the project is to demonstrate the feasibility of emulating industry proven business solutions to streamline workflow processes and further improve collections. VA is moving forward with the project and expects to select the recommended product in April 2003 and complete installation by September 2003. Based on the outcome of the pilot, a recommendation for national deployment will follow.

MEDICAL CARE WAITING LINES

Question. How many veterans are waiting to get a VA doctors appointment?

Answer. As of April 2003, there are 167,852 veterans on the waiting list.

Question. How is VA going to end the waiting list?

Answer. It is estimated that if the current rate at which new enrollment for priority 1–7 veterans remains constant and the rate at which veterans are added and removed from the wait list remains constant, then the wait list will be ended by February of fiscal year 2004.

VA is aggressively working on its Advanced Clinic Access initiative to make office practice efficiencies. By implementing these principles, clinics can then free up slots to meet the increased demand.

Question. How long does it take a veteran to get a specialty care appointment like dermatology and audiology?

Answer. For patients that have scheduled appointments, the average next available wait time as of February 2003 is 61 and 28 days for Dermatology and Audiology, respectfully. For patients placed on the wait list the wait time is 117 days and 158 days, respectfully.

Question. What standards does VA have for waiting times?

Answer. VA has the standard to schedule appointments within 30 days of the desired appointment date. This is quantified by measuring the average waiting time for patients requesting the next available appointment and requires that there are no patients on the wait list waiting more than 30 days for their appointment.

Question. How do these compare to the private sector?

Answer. VA was unable to find benchmarks for similar health care systems.

CLAIMS PROCESSING WAITING TIMES

Question. What is the current processing time for claims?

Answer. VBA's current processing time for rating related claims is 189.5 days for the month of March. The cumulative performance for the period from October 2002 through March 2003 is 198.5 days.

Question. What is the goal?

Answer. The cumulative target for average processing time for March 2003 is 190.6 days. VBA will continue to improve the average processing time for rating related claims. Specific station performance targets have been established in line with the Secretary's goal of 100 days average processing time for rating related actions.

Question. Why did average processing times increase from six to seven months last year?

Answer. For the month of March 2002, VBA's average processing time for rating related claims was 233.5 days. During the first six months of fiscal year 2002, the cumulative average processing time for rating related claims was 224.3 days. Over the last year, VBA has improved the average processing time for rating related claims by 44 days, from 233.5 days in March 2002 to 189.5 days in March 2003.

Question. If times are increasing, how is VA going to make its goal?

Answer. The leading timeliness indicator of performance is average days pending, rather than average processing time. In October 2002, VBA's average days pending was 168.2 days. In March 2003, the average days pending had improved to 144.5 days. This downward trend for average days pending indicates that our oldest claims are being processed. As these older claims are removed from the inventory, the processing time for rating related claims will continue to improve.

Question. How much funding does VA anticipate devoting to improving claims processing time in 2004?

Answer. The Veterans Benefits Administration has budgeted $22.3 million in 2004 to improving claims processing time. The following initiatives have been devoted to accomplishing these improvements:

Training & Performance Support System (TPSS)	$2,601,000
Compensation & Pension Evaluation Redesign (CAPR)	3,821,000
Benefits Replacement System (VETSNET)	9,200,000
Data Centric Benefits Integration (DCBI)	6,662,000
Total	22,284,000

A detailed description of these initiatives is contained in the 2004 Budget Submission, Volume 1, Benefits Programs, on pages 2–25 through 2–31.

Question. How many new employees has VA hired?

Answer. VBA hired approximately 150 additional Veterans Service Representatives (VSRs) and 150 additional Rating Veterans Service Representatives (RVSRs) in December 2002.

Question. How will VA retain these new employees so they will be able to make a real difference?

Answer. The RVSRs were recruited through the Federal Career Intern Program. To attract the best-qualified candidates, VBA utilized the same "focused recruitment activities" that were developed to attract nurses and other health care professionals. Experience has demonstrated that people with some medical training or experience in the health care field develop the necessary skills of an RVSR more rapidly and become proficient within a relatively short time period (two years).

Under the Federal Career Intern Program, new employees are enrolled in a comprehensive two-year training program. The employees will receive five weeks of centralized classroom training. They will use all available Training and Performance Support System (TPSS) modules at their home station. In addition, mentors have been assigned to the new employees to assist them with processing claims. Mechanisms have been established to track progress of these new hires during the two-year training program. VBA believes that the targeted recruitment, the structure of the Federal Career Intern program, the comprehensive training schedule and the assignment of mentors will assist in retaining these new employees. (VBA)

Question. How will VA ensure accuracy while trying to reduce times?

Answer. Budget authority of $621.4 million and 6,816 FTE (without OBRA) are requested to fund the discretionary portion of the Compensation program in 2004. Compared to the 2003 current estimate, budget authority is expected to show a net increase of $15.0 million.

Budget authority of $151.7 million and 1,635 FTE (without OBRA) are requested to fund the discretionary portion of the Pension program in 2004. Compared to the 2003 current estimate, budget authority is expected to decrease by $2.4 million.

In developing the 2004 budget, VBA did not assume there would be armed conflict with Iraq. Therefore, our workload and performance projections did not address the potential effects. However, we believe the reorganization of service centers into specialized work teams, as prescribed by the Claims Processing Task Force report, will increase work efficiencies in the Compensation program. Based on workflow analysis, VBA believes the discretionary portion of the compensation program budget will be sufficient.

While the discretionary portion of the pension program budget shows a decrease, we believe that the consolidation of pension workload in the Pension Maintenance Centers will lead to a gain in workflow efficiencies. Therefore, the reduction in this area should not negatively affect the pension claims process.

PHYSICIAN TIME AND ATTENDANCE

Question. What is VA doing to ensure that when VA is paying a doctor, the doctor is working for veterans?

Answer. By December 31, 2002, facility Directors were required to make all part-time VA physicians aware of VA time and attendance procedures, and all part-time VA physicians were required to certify that they were aware of and understood these requirements. The Under Secretary for Health also issued a VHA Directive (copy attached) that:

—Outlined everyone's responsibilities related to this issue; and

—Required facility Directors to:

—Review the appointments of part-time physicians to determine whether they were consistent with patient care needs,

—Establish procedures for monitoring the attendance of part-time physicians; and

—Certify to the Director of their Veterans Integrated Service Network that the above actions had been completed.

Question. What staffing standards are in place for part-time doctors?

Answer. In the past, VA managers made staffing decisions based on a variety of factors such as anticipated physician productivity, characteristics of assigned patient populations, prior and anticipated workload, waiting times, referral patterns, availability of funds, as well as the availability of staff or equipment needed to support and/or complement the services to be acquired. VA is now managing primary care workloads through panel size (see below); however, we are aware of the need for more specificity in this area and are developing a physician productivity model in four key outpatient areas: primary care, cardiology, urology, and ophthalmology. These models will help local managers more accurately assess the need for physician staff.

Question. How does VA estimate the number of doctors it needs? Is this comparable to the private sector?

Answer. Local VA officials are currently estimating their requirements for primary care physicians based on panel size or based on the numbers of patients assigned to each primary care physician. This methodology is comparable to the private sector; however, VA panel sizes are smaller because of differences in patient acuity, age, incidence of disease, and other population characteristics.

Question. Part-time doctors are critical to the VA—they often also work for affiliated research institutions and have many demands on their time. How does VA communicate clearly to doctors about keeping track of their time?

Answer. Medical Center Directors and Chiefs of Staff are responsible for ensuring all part-time physicians are made aware of their responsibilities with respect to VA time and attendance procedures. All part-time physicians recently certified their understanding of VA policies and procedures. VA officials are also responsible for enlisting the cooperation of affiliate institutions in the implementation of VA time and attendance policies and procedures.

Question. How does VA keep track of physician time, especially for part-time doctors?

Answer. Supervisors establish tours of duty for all full-time and part-time employees and place these tours in an automated "Enhanced Time and Attendance" system, which generates electronic timecards every two weeks. Employees also request and obtain supervisory approval for absences through this system (e.g., annual leave, excused absence, leave without pay). Supervisors are responsible for ensuring that employees under their supervision were working or that the employee's absence was approved. After the supervisor verifies the employee's presence (by visually noting the employee's presence, calling the employee's work number, reviewing work records, etc.), the supervisor asks the timekeeper to electronically record the employee's attendance. At the end of the 2-week period, electronic timecards are certified by the supervisor and released to the payroll activity for payment.

VA established "Adjustable Work Hours," a program to accommodate varying VA patient care needs and part-time VA physicians with VA or non-VA patient care, research, or educational responsibilities that makes adherence to the same scheduled tour of duty every 2 weeks difficult. A work schedule is established for these employees, but they may, with prior supervisory approval and consistent with VA patient care requirements, adjust a portion of the tour (up to 75 percent) to meet these demands. The remainder of their tour is considered "core time" or time during which the employee must be present unless granted an appropriate form of leave or absence. All part-time physicians who have been authorized to be on adjustable work hours must record their time and attendance on subsidiary timesheets, which are certified by their supervisor and entered into the Enhanced Time and Attend-

ance system by the timekeeper. After certifying the electronic time card, the records are released to the payroll activity for payment. As with other employees, supervisors are responsible for ensuring that employees on adjustable work schedules were either present or that their absence had been approved.

Question. How does VA estimate the number of doctors it needs?

Answer. Local facility managers are responsible for estimating the numbers and types of physicians needed to meet their patient care requirements. As indicated above, these decisions are based on a variety of factors; however, national productivity standards are being developed to assist them in making these determinations.

LONG TERM CARE

Question. The budget request proposes to limit nursing home care. Please explain this proposal.

Answer. VA plans to provide nursing home care to all veterans mandated under the Millennium Act when those veterans in need of nursing home care choose to receive it from VA. In addition, VA plans to provide nursing home care to veterans who are in the discretionary group, with priority given to those in need of post-hospital rehabilitation or special care, hospice, respite, intensive geriatric evaluation and management, and veterans with a spinal cord injury/disease and in need of nursing home care. In accordance with the recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care, VA will also continue to support a rising number of veterans in State home nursing homes. Increasingly, however, VA anticipates providing needed care for elderly veterans in less restrictive, less costly home-and community-based non-institutional settings.

Question. What are the consequences of this proposal? How many veterans will not receive nursing home care under this proposal?

Answer. VA's fiscal year 2004 budget policy would limit nursing home care in VA nursing homes and contract community nursing homes to Priority 1 veterans rated 70 percent service-connected disabled or greater or who require nursing home care because of a service-connected disability and to other veterans in need of post-acute rehabilitation, special or extensive care, comprehensive geriatric evaluation and management services, respite care, or hospice care. VA will provide nursing home care for all veterans who are mandated to receive nursing home care under the provisions of the Millennium Act, who seek to receive such care from VA, and whose medical and personal circumstances require such care. The budget continues to support increases in State veterans nursing home care—generally a less acute level of care. The fiscal year 2004 budget also recognizes that a substantial portion of long-term care needs are more appropriately met in non-institutional settings by providing for increased census in home and community-based services, including home respite that was authorized by the Millennium Act and a new home hospice service. This strategy will help assure that VA Nursing Home Care Units are available for care of service-connected veterans and for post-acute rehabilitation and special care needs while allowing veterans who do not need this level of care to receive care in their homes or closer to their homes in community settings.

In 2004, VA will treat an additional 2,261 average daily census (ADC) over the 2003 level in a combination of institutional and non-institutional care settings.

Question. Will VA do this by regulation, or does it require authorizing legislation?

Answer. VA understands that a change to the Millennium Act is required in order to reduce the level of effort in VA nursing homes below the 1998 baseline level. VA is proposing that VA's three nursing home care programs (VA operated, contract community, and State home), VA and State domiciliary, and VA and contract home and community-based care in total be utilized as the 1998 baseline.

Question. What is the status of VA's implementation of long term care overall?

Answer. VA recently submitted to Congress an extensive report entitled, "VA Extended Care: January 2003 Report to Congress of VA's Experience Under the Millennium Act". A few highlights from that report include:

—From fiscal year 1998–2001, the proportion of VA LTC patients treated in outpatient settings has grown from 57 percent to almost 64 percent;

—The number of VA LTC patients treated in inpatient settings grew by 6.7 percent;

—The average daily census (ADC) in VA nursing homes declined by 12 percent even though the number of patients grew (because of shorter lengths of stay);

—ADC for respite care and geriatric evaluation and management units located in VA Nursing Home Care Units grew over 50 percent;

—The budget for VA LTC programs grew by $200 million;

—Full-time equivalent employees increased for both nursing home care units and outpatient LTC programs;

—80 percent of patients surveyed about VA home-based primary care rated their care as very good or excellent.

Since passage of the Millennium Act in November 1999, VA has issued directives on the new eligibility requirements, the new and expanded program types, and co-payments in an effort to guide implementation of the Act.

Question. How much will VA spend on long-term care in 2004?

Answer. Estimated obligations for fiscal year 2004 are approximately $2.8 billion for institutional care and approximately $549 million for home- and community-based care.

Question. What is the status of the long-term care assisted living pilots?

Answer. VA is carrying out a three-year Assisted Living (AL) Pilot in Network 20 (Oregon, Washington, Idaho, Alaska). The pilot began enrolling veterans in January 2002 and to date has placed 286 veterans in AL facilities with which VA has established a contract. VA is authorized to pay the cost of AL for up to 6 months and then the veteran transitions into another payment arrangement (Medicaid or private pay) with the assistance of VA staff. The AL pilot is being evaluated by two of VA's Health Services Centers of Excellence. The evaluation report will be submitted to Congress in October 2004, 90 days before the end of the pilot.

PATIENT SAFETY IN MEDICAL RESEARCH

Question. How does VA safeguard patients who participate in VA research studies?

Answer. In safeguarding research participants, VA follows the Common Rule (Federalwide Policy for the Protection of Human Research Subjects), found at 38 CFR Part 16, as well as pertinent regulations of the Food and Drug Administration. These regulations and implementing policy require Institutional Review Board Review of research involving human subjects of research, informed consent, and assurances from each VA Medical Center conducting human research of compliance with the Common Rule.

Within VA, the Secretary recently approved establishment of the Office of Human Research Oversight (OHRO). This new office will be responsible for performing the oversight functions formerly performed by the Office of Research Compliance and Assurance (ORCA). It will investigate allegations of research misconduct and improprieties, develop event specific protocols as needed, and establish and implement procedures to report non-compliance with VA regulations and policies. In addition to staff in VA Central Office, OHRO will operate five field-based offices located at the former sites of the ORCA Regional Offices in Bedford, Massachusetts; Washington, D.C.; Decatur, Georgia; Chicago, Illinois; and Moreno Valley, California. At the same time, the new Program for Research Integrity, Development and Education (PRIDE) has been established within the Office of Research and Development (ORD). PRIDE will have responsibility for the training, education, and policy development functions formerly accomplished by ORCA.

We expect that this new structure will enhance our ability to provide effective research oversight, while improving our ability to identify, communicate, and provide necessary training on complex issues in a timely and responsive manner. It will strengthen protection for our human research subjects, and the support and guidance we provide our research community.

Question. How does VA make sure that patients are fully informed of the risks of the research?

Answer. VA follows the Common Rule and the FDA regulations that require that, unless appropriately exempted or waived under regulation, all volunteers in research be fully informed through the informed consent process of the purpose of the research risks and possible benefits of research in which they are asked to participate; whom to contact for additional information; any compensation in case of injury; that they may choose not to participate or may withdraw without losing any benefits to which they are otherwise entitled; as well as other information stipulated by regulation and policy. The information to be provided and the informed consent process is approved and monitored by the Institutional Review Board. ORCA has also produced a brochure entitled "I'm a Veteran. Should I Participate in Research?" to help veterans understand some basics about research in the VA and their rights in research. The brochure, which has been widely distributed within VA, will also be produced in Spanish. A video is also in production to convey the same information to the veterans. ORCA has also produced information letters regarding informed consent for the VA research community and other educational initiatives dealing with this topic. The adequacy of the informed consent process is a key factor in oversight of VA facilities in activities undertaken by ORCA.

VA's ORD has initiated research in how to improve the quality of the informed consent and the consenting process. The project entitled "Enhancing Quality of Informed Consent" (EQUIC) will attempt to determine the success and validity of the informed consent process by interviewing subjects immediately after they have given informed consent for a study. The information gained through these studies will be used to improve the informed consent and the informed consent process.

During the past 3 years ORD has placed more emphasis on both the written informed consent and the consenting process through quality improvement efforts that include the ongoing EQUIC study that surveys research participants after they have consented to participate in a clinical trial; the development of focus groups composed of veterans that assist in the review; development of informed consents; presentations by ORD staff to national and regional conferences; and the State of the Art conference on informed consent held March 7–9, 2001.

In a recent quality improvement survey conducted by ORD, 97 percent of responding research subjects agreed with the statement "The Informed Consent process including discussion with study staff gave me the information needed to make an informed decision about whether or not to participate in the study."

Question. What are VA's safety standards for research involving patients?

Answer. VA adheres to the Common Rule at 38 CFR Part 16, FDA regulations at 21 CFR, and the implementing instructions developed by VA (M–3, Part 1, Chapter 9). A primary method of ensuring that risks to research participants is minimized is through Institutional Review Board review as required by the regulations, oversight at the VA facility through the research service and compliance personnel, and through ORCA.

Question. Does VA ensure that all of the medical professionals who treat veterans have current licenses and credentials?

Answer. The VA uses a peer review credentialing process with standards that are set forth by the Joint Commission on Accreditation of Healthcare Organizations. In this process the qualifications of providers, as well as periodic reviews of currently employed providers, are verified prior to appointment, reappointment, and privileging. Credentialing must be completed prior to initial appointment or reappointment and before transfer from another medical facility. In 2001, the Veterans Health Administration (VHA) implemented VetPro, the VA Credentials Data Bank. As an Internet enabled program, the VA is able to obtain complete, validated, and verified credentials. The credentialing process includes verification of the individual's professional education, training, licensure, certification, and review of health status, previous experience (including any gaps greater than 30 days in training and employment), clinical privileges, professional references, malpractice history, and adverse actions or criminal violations, as appropriate. Provider credentials are screened through the State Licensing Board (SLB) for all current and previously held licenses, the Federation of State Medical Boards (FSMB) Disciplinary File, and the National Practitioner Data Bank (NPDB). All information obtained through the credentialing process is carefully reviewed by the Facility Executive Committee of the medical staff before employment/privileging decision are made.

Question. How does VA headquarters make sure that the networks are following these standards and procedures?

Answer. *Research Safeguards.*—Information and instruction on the standards and procedures are coordinated through VA Central Office to the network offices. Several network offices have compliance officers who help educate the facilities about their responsibilities and conduct oversight if issues are detected. ORCA informs individual network offices of actions regarding oversight compliance issues. ORCA has also provided extensive and formal training for all network leadership and facility leadership on human subject protections issues. In addition, ORCA has issued information letters, alerts, and other updates to remind the networks of their responsibilities and provides copies to the network leadership on all official actions that it takes. ORCA negotiates the assurances of compliance required by the Common Rule with all VA facilities conducting research. Network directors have taken web-based training modules to describe the commitments made in the assurance and the basic protections afforded to subjects in VA research as required by the Common Rule and VA policy.

The Chief Research and Development Officer requires all research offices to verify the credentials of not only VA employees but of all individuals who perform independent clinical activities as part of their research duties. In addition, all other individuals involved in human studies research must have their credentials confirmed, a scope of work established, and a record of such maintained and available for review. Sites must check the licenses of all licensed staff annually, and facilities will create an electronic means of tracking all without compensation (WOC) employees

involved in human subjects research to facilitate the regular checking of these individuals against exclusionary lists.

Credentialing in General.—By monitoring the VetPro credentialing process, VA can determine the extent to which VISNs and facilities are using this system. The system requirements ensure that the standards and procedures are followed to the extent that providers are credentialed via VetPro.

FORT HOWARD

Question. What is the status of the Mission Change and Enhanced use project underway at Fort Howard? What is the current timetable for the project?

Answer. The Mission Change portion is completed. The current timeline for the Enhanced-Use project is as follows:

	Target	Completed
Submit Business Plan	12/2002	12/06/2002.
Business Plan Approval	01/2003	01/20/2003.
Public Hearing	02/2003	02/26/2003.
Designation to Congress	02/2003	Pending (VACO).
Solicitation/Request for Proposal (RFP)	03/2003	3/26/2003.
Evaluation	07/2003.	
VA Capital Investment Board Review	09/2003.	
OMB Notification and Review	10/2003.	
Congressional Notification	10/2003.	
Award	11/2003.	

Question. What is the method the VA will use to broadcast [send out] its Request for Proposals (RFP) for Fort Howard? Will the VA rely solely on newspaper notices or will there be targeted mailings to companies which provide the type of development the VA is seeking at Fort Howard?

Answer. Targeted mailings were made to over 240 parties that have previously expressed interest in Ft. Howard, or that have expressed interest or participated in other similar enhanced use projects. The RFP was also advertised in local newspapers.

Question. What is the final date due for the RFP's? If there are no qualified bidders after the due date, will the VA make adjustments to the RFP and re-broadcast? What affect would such re-broadcast have on the current timeline for Ft. Howard?

Answer. Proposals in response to the RFP are due on June 13, 2003. If there are no qualified proposals, VA will interview some of the firms that had expressed interest in an attempt to assess the reasons for the lack of response, and will revise and adjust the RFP if appropriate. Any such assessment, revision, and re-issue of the RFP was not envisioned in the aggressive timeline, and would add in excess of 90 days to future milestones.

Question. Will VA require the inclusion of assisted living and nursing care units at Fort Howard?

Answer. No. The RFP specifies VA's preference for all elements of a continuous care retirement community but does not require them. Instead it allows potential proposers to present a plan for the redevelopment that they deem most appropriate and feasible.

Question. Veterans with inpatient needs are being referred to the Baltimore VAMC. What has the VA done to prepare the Baltimore facility for its expected increase in workload? What facility improvements are being made? What is the VA doing to ensure that healthcare workers at the facility are able to provide quality customer service to an increased workload?

Answer. The Fort Howard Mission Change did not impact the Baltimore VAMC. The Baltimore division of the VA Maryland Health Care System inpatient beds is dedicated to acute medical care and served the acute medical needs of the patients at Fort Howard prior to the Mission Change. Consequently, there is no projected impact on inpatient care at Baltimore as a result of the Mission Change.

The inpatient programs that where located at Fort Howard were dedicated to intermediate medicine. The Mission Change relocated 68 of the 85 existing beds to the Loch Raven and Perry Point facilities, where excess capacity existed within the healthcare system. At the time the inpatient beds were relocated, the average daily census in intermediate medicine was 68 depicting that excess capacity existed. The VA Maryland Health Care System was given permission to close 17 beds as a result of the low occupancy rate.

Question. Will outpatient services continue at the Fort Howard campus throughout the entire transition?

Answer. Yes. The Fort Howard campus will retain a Community Based Outpatient Clinic that will be staffed by VA physicians and support staff.

Question. If the State does not authorize a new State Veterans Home at Fort Howard, what impact will it have on the Enhanced Use plan?

Answer. The RFP requires all proposers to identify a 7-acre parcel of the campus that they will set aside in their redevelopment plan for future use as a site for a State Nursing Home. If at some future time the Department, after consultation with the State of Maryland, determines that this State Home is no longer a possibility, the Department may choose to offer this parcel to the enhanced-use lessee for additional consideration or could choose to pursue a separate enhanced-use lease for a purpose as yet to be determined.

HOMELAND SECURITY

Question. VA's Fourth Mission is to serve as a backup to the DOD healthcare system in times of national emergency. What does VA propose to spend in 2004 to prepare for this mission?

Answer. VA does not budget separately for preparedness to execute its plans to provide back up to the DOD health care system in times of war or national emergency. Medical preparedness actions to support DOD in wartime are part of an overall integrated comprehensive Emergency Management Program (EMP) used within VA and, in particular, the Veterans Health Administration (VHA). This concept employs an "all hazards" approach to emergency preparedness that addresses the broad range of threats and missions that VA can be called upon for response. This includes not only providing care to active duty service members in wartime, but also requests under the Stafford Act and other authorities for VA assistance in domestic disasters or terrorist incidents. Each of VHA's medical facilities must, as mandated by the Joint Commission on Accreditation of Healthcare Organizations, employ this comprehensive approach in development of their local Emergency Operations Plans. This includes planning for receipt of military casualties under activation of the VA-DOD Contingency Plan, as well as for other contingencies associated with natural or manmade events within their communities.

Question. If there is a biological attack in Baltimore, what would be the role of the VA hospital?

Answer. A biological attack would most likely prompt an activation of the Federal Response Plan (FRP). Under Emergency Support Function #8, "Health and Medical," of the FRP, VA is cited as a support agency. The lead agency is the Department of Health and Human Services (HHS).

VA could be tasked to provide support in several ways. The mostly likely forms of support would be:

—Pharmaceuticals for immediate treatment and as prophylaxis (e.g., antibiotics, as were administered after the anthrax incidents post 9–11). VA may oversee or assist with coordinating the logistics of various caches (Centers for Disease Control (CDC), HHS) or in providing pharmaceuticals from its internal sources.

—VA may be requested to provide staff (especially clinical) to assist in administering pharmaceuticals and rendering treatment.

—VA may be asked to support supplies (e.g., swabs, syringes/needles, culture materials) or equipment (ventilators, dialysis, or other biomedical equipment depending on the biological agent and its effects). In the short term, many of these requested resources would be provided by the Baltimore VA Medical Center.

VA's role in such an attack would also depend on the local emergency plan and specific expectations cited in the plan. For instance, if the event is assessed to warrant decontaminating victims, VA may, through the Local Emergency Preparedness Committee (LEPC) be cited as a source to provide decontamination.

Finally, in such an attack, the local VA medical center will activate their internal disaster plan, including implementing heightened security, facility level decontamination (and other preparedness measures), staff call-back roster implementation and vigilant surveillance, and reporting of actual or suspected bio-terror victims to the public health authorities.

Question. Are employees there being vaccinated for smallpox? If yes, how? If not, why not?

Answer. Yes, as of March 13, five members of VAMHCS have been vaccinated through the State plan as implemented through the University of Maryland Hospital. The remainder of the Smallpox Vaccination Team and of the Smallpox Healthcare Response Team has not been vaccinated. The Maryland Health Care System plans to vaccinate other team members when the VA supply of vaccine becomes available.

PHYSICIAN ASSISTANT ADVISOR

Question. In previous Committee reports, the Committee has encouraged VA to make the Physician Assistant Advisor a full-time field position in close proximity to headquarters. What is the status of this position? Is it full-time? Where is it located?

Answer. The Physician Assistant (PA) Advisor position was created pursuant to The Veterans Benefits and Health Care Improvement Act of 2000 (Public Law 106–419) that directed VHA to create a position of PA Advisor to the Office of the Under Secretary for Health. This was an unfunded mandate. To prevent delay, VHA elected to create the position as a half-time national basis and half-time field-based position. The part-time PA Advisor reports within the Office of the Chief Consultant for Primary and Ambulatory Care in Patient Care Services, VHA. The current PA Advisor is based at the Milwaukee, WI, VAMC where he was employed before his appointment to this position.

While Congress's interest in having a full-time PA Advisor is clear in principle, the current arrangement of the PA Advisor as part-time at the national level, while continuing to practice in a clinical capacity at the field level, is working well. The PA Advisor has established a highly functional communications network for PAs, has a national Field Advisory Group to assist him, serves on national committees and workgroups, and provides advice regarding clinical practice and employment and utilization of PAs within VHA. He is able to communicate effectively when critical time responses are required from the field or from VHA about PA issues.

There are distinct benefits of having a field-based practicing clinical PA in the role of PA Advisor, and this is true for the other decentralized program directors as well. In addition, field-based positions allow for the recruitment of the best-qualified individuals rather than just those who are willing to move to Washington, DC. Consequently, VHA is not recommending that the PA Advisor be established as a VACO-based full-time employee equivalent position at this time.

Question. What other Advisor positions are full time? Which ones are located at or close to headquarters?

Answer. The PA Advisor position, which represents approximately 1,400 PAs within VHA, is compatible with the other occupational representatives within Patient Care Services, all of who perform these duties on a part-time basis. Within VA's Office of Patient Care Services, the National Directors of Pathology, Radiology, Optometry, Ophthalmology, Podiatry, Neurology, and Anesthesia have part-time VACO appointments. The Chief Consultants for Spinal Cord Injury, Physical Medicine and Rehabilitation, and Diagnostic Services are also part-time VACO appointments. Of these, only the current Chief Consultant for Physical Medicine and Rehabilitation is based at the Washington, DC, VAMC where she is also Chief of the Audiology and Speech Pathology Service. The current Director of Optometry is based in Baltimore, MD. All other incumbents are at more distant locations, ranging from West Haven, CT, to the West Coast.

Question. What is the budget request for travel and administrative support of this position?

Answer. The PA Advisor has a travel budget to allow trips to VACO and to PA national meetings. This support allows him to perform his duties and meet with other federal PAs. VA provided $10,565 in fiscal year 2002 for the PA Advisor to travel to VACO for face-to-face meetings. VA also provided funding for a face-to-face meeting of the PA Field Advisory Group, which is composed of six members including the PA Advisor.

VA has allocated $6,600 to the PA Advisor for fiscal year 2003 travel. This funding level was established while VA was on continuing resolution and is commensurate with that of the Directors of Optometry and Podiatry, who are also within the Office of the Chief Consultant for Primary and Ambulatory Care. Funding for a face-to-face meeting of the PA Field Advisory Group is not provided in the fiscal year 2003 budget due to limits on all VHA travel funding. When the PA Advisor serves on VHA committees or workgroups, travel may be funded through those groups. If additional funds become available during fiscal year 2003, they will be distributed equitably in response to need. Funding of $6,600 has been requested for fiscal year 2004.

Administrative support for the PA Advisor is not specifically funded, but the administrative support personnel in VA's Office of the Chief Consultant for Primary and Ambulatory Care are available to assist with administrative duties such as correspondence and responses to information requests. Satellite education conferences are supported by the Employee Education Service (EES) and face-to-face conferences for PAs have also been supported by EES in the past. Conference call capability is readily available to the PA Advisor.

TRANSITIONAL HOUSING

Question. The budget proposes to convert Guaranteed Transitional Housing from a mandatory to discretionary account. Why?

Answer. VA has found that many potential developers of transitional housing are in need of a cash grant or other sources of funds that do not require regular repayment. Based on numerous discussions with potential developers, VA has concluded that a grant would be of more benefit to such developers than a loan.

The key advantage for the Federal government of changing from a guaranteed loan to a grant program is the reduction of financial loss resulting from loans defaulting. The current pilot program, as a loan guaranty, is full of risks (pre-development, construction, operating risks) and currently has a subsidy rate of 48.25 percent. The potential sponsors could apply for grant funding, in lieu of a loan guaranty, where repayment is not required.

The proposal to convert this loan guaranty to a grant program resulted after VA's experience in trying to design the loan guaranty program and meeting with potential partners under this pilot program. In addition, numerous representatives of government, private and public lending institutions, and real estate developers of multifamily housing projects have advised VA of the high risk involved and high rates of defaults by borrowers.

Veterans could be better served with the proposal to change from a loan guaranty to a grant program because VA believes more developers would be interested in and able to complete projects with the assistance of a grant rather than a loan that must be repaid. Therefore, there exists the likelihood that more projects will be completed and more beds will become available to homeless veterans if this program were converted to a grant.

Question. How much will this proposal cost in 2004? How much is it expected to cost each of the next five years?

Answer. VA anticipates spending approximately $9.6 million per year in grants to help develop long-term multifamily transitional housing for homeless veterans. Across a 5-year period, VA would offer approximately $48 million in grants. In addition, VA estimates eight FTE to administer and oversee this program at an average cost of $52,000 per FTE. Staffing costs would be approximately $416,000 per year. Cumulative staffing costs would be $2.08 million across a 5-year period. VA also anticipates spending $869,000 per year on contracts to help implement and administer the program. Contracting costs would be $4.345 million across a 5-year period.

QUESTIONS SUBMITTED BY SENATOR TOM HARKIN

Question. Mr. Secretary, as you know, physician assistants provide vital care to our nation's veterans. Physicians Assistants had 5.2 million contacts with VA patients last year alone. Congress took an important step in recognizing this contribution when passing the Veterans Benefits and Health Care Improvement Act of 2000 (Public Law 106–419), which included the creation of Physician Assistant Advisor position for the Veterans Health Administration (Title II, Subtitle A, Sec. 206). Since that time, the Committee has included language in fiscal year 2002 and fiscal year 2003 requesting VHA to make the position a full-time, field-based position with adequate travel and administrative support. The fiscal year 2003 language asked for a report on the status of this request. This report was due March 3, 2003. I would like a report from VHA on the amount of travel and administrative support for the position in fiscal year 2002 and fiscal year 2003, as well as proposed fiscal year 2004 support? What is the timetable for making the PA Advisor position a full-time position, as requested by the Committee?

Answer. *Travel and Administrative Support.*—The PA Advisor has a travel budget to allow trips to VACO and to PA national meetings. This support allows him to perform his duties and meet with other federal PAs. VA provided $10,565 in fiscal year 2002 for the PA Advisor to travel to VACO for face-to-face meetings. VA also provided funding for a face-to-face meeting of the PA Field Advisory Group, which is composed of six members including the PA Advisor.

VA has allocated $6,600 to the PA Advisor for fiscal year 2003 travel. This funding level was established while VA was on continuing resolution and is commensurate with that of the Directors of Optometry and Podiatry, who are also within the Office of the Chief Consultant for Primary and Ambulatory Care. Funding for a face-to-face meeting of the PA Field Advisory Group is not provided in the fiscal year 2003 budget due to limits on all VHA travel funding. When the PA Advisor serves on VHA committees or workgroups, travel may be funded through those groups. If additional funds become available during fiscal year 2003, they will be

distributed equitably in response to need. Funding of $6,600 has been requested for fiscal year 2004.

Administrative support for the PA Advisor is not specifically funded, but the administrative support personnel in VA's Office of the Chief Consultant for Primary and Ambulatory Care are available to assist with administrative duties such as correspondence and responses to information requests. Satellite education conferences are supported by the Employee Education Service (EES) and face-to-face conferences for PAs have also been supported by EES in the past. Conference call capability is readily available to the PA Advisor.

Full-time Status.—The Physician Assistant (PA) Advisor position was created pursuant to the "Veterans Benefits and Health Care Improvement Act of 2000" (Public Law 106–419), which directed VHA to create a position of PA Advisor to the Office of the Under Secretary for Health. VA elected to create the position as a half-time national basis and half-time field-based position. The part-time PA Advisor reports within the Office of the Chief Consultant for Primary and Ambulatory Care in Patient Care Services in VHA. The current PA Advisor is based at the Milwaukee, WI, VAMC where he was employed before his appointment to this position.

The current arrangement of the PA Advisor as part-time at the national level, while continuing to practice in a clinical capacity at the field level, is working well. The PA Advisor has established a highly functional communications network for PAs, has a national Field Advisory Group to assist him, serves on national committees and workgroups, and provides advice regarding clinical practice and employment and utilization of PAs within VHA. He is able to communicate effectively when critical time responses are required from the field or from VHA about PA issues.

The PA Advisor position, which represents approximately 1,400 PAs within VHA, is compatible with the other occupational representatives with in Patient Care Services, all of who perform these duties on a part-time basis. Within the Office of Patient Care Services, the National Directors of Pathology, Radiology, Optometry, Ophthalmology, Podiatry, Neurology, and Anesthesia have part-time VACO appointments. The Chief Consultants for Spinal Cord Injury, Physical Medicine and Rehabilitation, and Diagnostic Services are also part-time VACO appointments. Of these, only the current Chief Consultant for Physical Medicine and Rehabilitation is based at the Washington, DC, VAMC, where she is also Chief of the Audiology and Speech Pathology Service. The current Director of Optometry is based in Baltimore, MD. All other incumbents are at more distant locations, ranging from West Haven, CT, to the West Coast.

There are distinct benefits of having a field-based practicing clinical PA in the role of PA Advisor. Field-based positions allow for the recruitment of the best-qualified individuals, not simply those willing to make the transition to the Washington, DC, area. Consequently, VA is not recommending that the PA Advisor be established as a VACO-based full-time position at this time.

Question. Mr. Secretary, can you tell me the current wait for appointments for new (non-emergent) patients at each of Iowa's facilities, the current plans for improving the situation, and how long you anticipate waits will be when those plans are implemented? Can you also compare the waits for appointments for new non-emergent patients in each of the VISN's?

Answer. There are two VA health care facilities located in the State of Iowa, VA Central Iowa Health Care System (Des Moines/Knoxville) and Iowa City VAMC.

The following chart provides waiting times to primary care for new non-emergent patients.

IOWA FEB 2003 WAITING TIMES

State	VISN	Station Number	Station Name	Clinic Type	Type of CBOC/ Division	Average New Patient Wait Time (Recoded as next available)
IA	23	636A6	Des Moines Division—Central Plains Health Network.	PRIMARY	VA PROVIDED	61.2
IA	23	636A7	Knoxville Division—Central Plains Health Network.	PRIMARY	VA PROVIDED	35.2
IA	23	636A8	Iowa City Division—Central Plains Health Network.	PRIMARY	VA PROVIDED	38.8
IA	23	636GC	Mason City	PRIMARY	VA PROVIDED	63.9
IA	23	636GF	Bettendorf	PRIMARY	VA PROVIDED	73.7

IOWA FEB 2003 WAITING TIMES—Continued

State	VISN	Station Number	Station Name	Clinic Type	Type of CBOC/ Division	Average New Patient Wait Time (Recoded as next available)
IA	23	636GH	Waterloo	PRIMARY	VA PROVIDED	59.6
IA	23	636GJ	Dubuque	PRIMARY	VA PROVIDED	125.2
IA	23	636GK	Fort Dodge	PRIMARY	CONTRACT	27.5

The Iowa City VAMC does not have a waiting list and can schedule an appointment for a new patient in less than 40 days, therefore, no other plans are being considered except for close observation of panel sizes to ensure that supply and demand are in balance.

At all of the Central Iowa sites, they are actively working on implementing the Advanced Clinic Access principles, and they have brought in a fee basis physician to see new patients to accelerate the process at Des Moines. Des Moines also added a Nurse Practitioner at Mason City CBOC in November. The projection is that by July 2003, Mason City will be at 30 days or less. Based on the current rate of new patients requesting appointments and those who had previously been scheduled at Des Moines while they were waiting for Mason City, it is projected to be late June before the waiting time will be within 30 days. In February and March, there were fewer applicants for care and that may also expedite the process.

The following data compares waits for new non-emergent patients by VISN:

VISN	New Patient Next Available Appointment
1	44.1
2	30.0
3	43.8
4	46.1
5	41.6
6	47.5
7	51.4
8	65.2
9	60.7
10	41.9
11	51.5
12	59.5
15	54.8
16	43.1
17	50.9
18	46.6
19	56.3
20	41.7
21	46.6
22	31.3
23	59.9

Question. Last year, I joined the Senators representing the veterans in VISN 23 in writing you about reform of the VERA model. As you know, a recent GAO report I requested found that the VERA model is unfairly hurting several VISN's and examined the effects of including Priority 7 patients, using more patient categories, and using more recent data to determine the distribution. Can you tell me what changes, if any, you plan to make to the VERA model in distributing fiscal year 2003 and fiscal year 2004 funds? Please also give me any analysis the VA has done on how changes to the VERA model would affect the distribution of health care funds.

Answer. *Fiscal Year 2003 VERA Model Changes.*—Based on the deliberations of VHA's internal VERA workgroups, and in response to a February 2002 General Accounting Office VERA report and the Rand Corporation recommendations, the Secretary approved the following improvements to the VERA methodology for fiscal year 2003:

—Move from a VERA three case-mix model to a VERA ten case-mix model. This change expands the VERA patient price groups from three (Basic Vested Care,

Basic Non-Vested Care, and Complex Care) to 10 (6 Basic Care price groups and 4 Complex Care price groups) and better recognizes a differentiation in VA's "core mission" patients (veterans with service connected disabilities or those with incomes below the current threshold or special needs patients, e.g., the homeless).

—*Additional Allocation for High-Cost Patients.*—This change provides an additional allocation to networks with the top 1 percent highest cost patients. This recognizes the impact on those networks with patients whose annual costs exceed $70,000, the threshold for the 1 percent highest cost patients. These networks will receive an additional allocation equal to the amount that a patient's actual costs exceed the $70,000 threshold.

—Implement a low cap (5 percent) and high cap (12.6 percent) for fiscal year 2003 funding increases above the final allocation received in fiscal year 2002. As a result, it is expected there will be no VERA adjustment or supplemental allocation provided in fiscal year 2003.

These fiscal year 2003 VERA refinements will improve the equitable allocation of funds to the 21 networks by recognizing the financial differences in "core mission" patients, by continuing the basic patient classification structure of the VERA model, by minimizing the incentives for unconstrained workload growth, and by eliminating the need for supplemental funding for networks during the year.

Priority 7 Veterans.—There was one VERA change recommended for fiscal year 2003 implementation that was not approved by the Secretary. In its February 2002 report on VERA (GAO–02–338), GAO recommended that VA "Better align VERA workload measures with actual workload served regardless of veteran priority group."

Based on a careful assessment of all policy options, the Secretary determined not to include non-service-connected Priority 7 Basic Care patients in the VERA model for fiscal year 2003. Although the inclusion of non-service-connected/non-complex care Priority 7 veterans in the VERA Basic Care category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of veterans with service connected disabilities or those with incomes below the current income threshold or special needs patients (e.g., the homeless), veterans who comprise VA's core health care mission.

VA experienced uncontrolled growth in the Priority 7 veterans (designated as Priority Group 8 for fiscal year 2003) when they were not included in the VERA model, and VA does not want to encourage unmanageable workload growth by including them in the VERA model in other than the Complex Care price groups. The allocation of fixed resources to networks is done on a zero sum basis. Increased resources for non-service-connected/non-complex care Priority 7 veterans would come at the expense of veterans who are service-connected, poor, or who require specialized services. The allocation of resources to areas with a disproportionate percentage of non-service-connected/non-complex care Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service-connected and lower income veterans.

Fiscal Year 2003 Network Funding Allocations.—The table below depicts VERA allocations for the 21 Networks in fiscal year 2003 compared to the VERA fiscal year 2002 year-end allocation.

FISCAL YEAR 2003 NETWORK ALLOCATIONS COMPARED TO FISCAL YEAR 2002 ALLOCATIONS

(Dollars in thousands)

Network	Fiscal Year 2002 VERA Year End Allocations	Fiscal Year 2003 VERA 10 (1% High Cost Adjust, 5% Low Cap, 12.6% High Cap)		
		Fiscal Year 2003 VERA Allocations	Dollars Shifted from Fiscal Year 2002 Base	Percent Change from Fiscal Year 2002
01 Boston	$943,383	$1,012,354	$68,971	7.3
02 Albany	507,386	556,418	49,032	9.7
03 Bronx	1,058,664	1,111,597	52,933	5.0
04 Pittsburgh	955,780	1,076,519	120,739	12.6
05 Baltimore	575,640	617,523	41,882	7.3
06 Durham	881,606	990,671	109,066	12.4
07 Atlanta	1,071,956	1,158,656	86,699	8.1
08 Bay Pines	1,470,056	1,655,761	185,705	12.6
09 Nashville	848,607	926,758	78,151	9.2
10 Cincinnati	697,551	771,274	73,723	10.6

FISCAL YEAR 2003 NETWORK ALLOCATIONS COMPARED TO FISCAL YEAR 2002 ALLOCATIONS—Continued

(Dollars in thousands)

Network	Fiscal Year 2002 VERA Year End Allocations	Fiscal Year 2003 VERA 10 (1% High Cost Adjust, 5% Low Cap, 12.6% High Cap)		
		Fiscal Year 2003 VERA Allocations	Dollars Shifted from Fiscal Year 2002 Base	Percent Change from Fiscal Year 2002
11 Ann Arbor	766,210	849,127	82,917	10.8
12 Chicago	898,572	978,050	79,478	8.8
15 Kansas City	717,747	761,453	43,707	6.1
16 Jackson	1,499,125	1,688,502	189,377	12.6
17 Dallas	850,104	936,733	86,629	10.2
18 Phoenix	731,784	803,265	71,481	9.8
19 Denver	483,243	528,463	45,220	9.4
20 Portland	840,081	902,764	62,683	7.5
21 San Francisco	947,781	1,062,177	114,396	12.1
22 Long Beach	1,082,849	1,219,641	136,791	12.6
23 Minneapolis	874,116	917,822	43,706	5.0
VHA Totals	18,702,243	20,525,528	1,823,285	9.7

Future Year VERA Changes.—The National Leadership Board (NLB) Finance Committee will continue to review and evaluate future potential enhancements to the VERA methodology. In addition to these refinements, a regression-based model being developed by the RAND Corporation, and a Diagnostic Cost Groups (DCGs) model will be evaluated for fiscal year 2005 and beyond.

Question. According to press reports last year, the VA health care system was short $400 million for fiscal year 2002. As you know, Congress approved an additional $417 million in supplemental funding to make up for this shortfall. Of this amount, $142 million had been requested by President Bush and was sent to the VA. Unfortunately, the President chose not to release a budget package that included the other $275 million. Can you tell me how large the shortfall for fiscal year 2002 was and how you made up for the shortfall? Do expect a shortfall in fiscal year 2003?

Answer. We do not anticipate a shortfall in fiscal year 2003. The demand for medical services in 2002 outpaced our capacity to provide timely, quality care to all who sought these services. As a result, we implemented policies to focus resources and care on our highest priority veterans—those with service connected conditions, low income and special needs veterans. To ensure that combat-disabled veterans can gain timely access to VA health care, VA published a regulation to provide for priority scheduling of appointments for veterans who are 50 percent or more disabled from service-connected causes and other veterans who are seeking care for their service-connected conditions. In the first quarter of fiscal year 2003, VA made an enrollment decision to stop enrollment of most new Priority 8 higher income veterans for care starting on January 17, 2003. This decision allows VA to continue to focus on the care of our highest priority veterans.

Question. Many of our veterans seek care at VA hospitals because of the excellent pharmacy benefits, sometimes even if they have another primary care physician. As you know, our elderly on Medicare do not have coverage for prescription drugs. Would it relieve some of the burden on the VA if Congress passed a real prescription drug benefit in Medicare?

Answer. We believe that in the context of the President's Medicare modernization framework, which would provide for a pharmaceutical benefit to Medicare beneficiaries, some burden on the VA could be relieved since more than half of the veterans who receive health care through VA are over age 65. According to data from the 2002 VHA Survey of Veteran Enrollees, 90 percent of Priority 8 enrollees and 87 percent of Priority 7 enrollees have some type of public (Medicare/Medicaid) or private health care coverage (compared to just 70 percent for Priority 5 and 73 percent for Priority 1 enrollees).

However, it is the combined effect of several factors that has resulted in the large increase in demand that has severely strained VA's ability to continue to provide timely, high-quality health care. First, the Veterans Health Care Eligibility Reform Act and the Millennium Health Care Act opened the door to comprehensive health care services to all veterans. Second, access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics. Third, our pa-

tient population is growing older and this had led to an increase in veterans' need for health care. Fourth, VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our health care system. (In this regard, however, VA has found that even though many patients initially come to VA for drugs, some ultimately used other services, including cardiology, urology, eye care, and inpatient care.)

VA will continue to face significant challenges, as the demand for health care services reaches unprecedented levels. At the same time, VA must continue to fulfill its core mission—providing timely access to high quality health care to veterans with service connected disabilities, low incomes, and those with special needs. The actuarial projections show that the increasing demand placed on VA health care system will continue to strain VA's ability to provide timely, high-quality health care for veterans in Priorities 1–6. VA expects to provide health care to 3.6 million patients in core Priorities 1–6 (service connected and low-income veterans) in fiscal year 2004, an increase of 5 percent over fiscal year 2003. Priorities 1–6 alone are expected to cost $9 billion more by fiscal year 2008 (over fiscal year 2003).

QUESTIONS SUBMITTED BY SENATOR TIM JOHNSON

Question. For the past several years, Congress has provided additional funds over the President's request for VA health care. While your fiscal year 2004 budget request has an increase over what was funded in fiscal year 2003, the Independent Budget estimates you are still about $2 billion below what is needed for veterans medical care.

Do you agree with the analysis of the VA's needs that is provided in the Independent Budget? Is your fiscal year 2004 VA medical care request sufficient to fund all the needs of the VA health system?

Answer. As with the President's budget, the total Independent Budget is well articulated and certainly has veterans' health care foremost in mind. However, there are two fundamental differences between the two budgets. The President's budget uses collections and management efficiencies to help offset the overall cost of the increased workload and utilization. The cost-sharing proposals in the 2004 budget only affect the lowest priority veterans in Priority 8 and non-service-connected veterans in Priority 7 and have been strategically priced to refocus the VA system on those veterans who need us most and those who need the specialized care VA provides. The management savings will be achieved by implementing a rigorous competitive sourcing plan; reforming the health care procurement process; increasing employee productivity; continuing to shift from inpatient care to outpatient care, a less costly alternative; and reducing requirements for employee travel, interagency motor pools, maintenance and repair services, operating supplies, and materials to redirect them to providing direct health care for veterans. When collections and efficiencies are taken into consideration, the President's budget request exceeds the Independent Budget by $108 million. However, the sufficiency of the VA medical care request is dependent on passage of the policies proposed in the 2004 President's budget.

Question. I recently had the pleasure of visiting several VA facilities in South Dakota. While there, I had the opportunity to talk to veterans who are having to wait up to a year to get an appointment. Nationally, according to the VA, there are over 200,000 veterans on waiting lists for appointments.

Does your budget request for fiscal year 2004 provide sufficient funds to eliminate the waiting lists for VA appointments? If not, what is your plan to end the long waits for appointments at the VA?

Answer. Yes, the 2004 budget proposes to reduce the average waiting time for new patients seeking primary care clinic appointments to 30 days in 2004, and reduce the average waiting time for next available appointment in specialty clinics to 30 days in 2004. VA is working to improve access to clinic appointments and timeliness of service. VA continues efforts to develop ways to reduce waiting times for appointments in primary and specialty care clinics. By refocusing VA's health care system on these groups, VA will be positioned to achieve our primary and specialty care access standards.

There are two VA facilities located in South Dakota. VA Black Hills Health Care System is an integrated facility with two campuses located in Fort Meade and Hot Springs. Sioux Falls houses the VA medical and regional office center and offers inpatient and outpatient primary and specialty care.

The Black Hills Health Care System has a waiting list of 24 patients and Sioux Falls VAM&ROC has a waiting list of 3,264 patients. When a name is removed from

a waiting list the average wait time for a new patient appointment in primary care is less than 60 days.

All of the medical facilities in South Dakota are using Advance Clinic Access practices to eliminate wait lists and reduce wait times. With the additional resources for new workload in fiscal year 2003, the network's plan is to release $2.1 million to Sioux Falls VAM&ROC. Wait lists at all facilities are expected to be eliminated by the end of this fiscal year.

The following chart provides waiting times to primary care for new non-emergent patients.

SOUTH DAKOTA FEB 2003 WAITING TIME

State	VISN	Station Number	Station Name	Clinic Type	Average New Patient Wait Time (Recoded as next available)
SD	23	438	Sioux Falls	PRIMARY	37.5
SD	23	438GD	Aberdeen (Brown County)	PRIMARY	49.6
SD	23	568	Fort Meade	PRIMARY	41.3
SD	23	568A4	Hot Springs	PRIMARY	54.6
SD	23	568GA	Rapid City SD	PRIMARY	47.1
SD	23	568HJ	Rosebud	PRIMARY	18.5
SD	23	568HM	Eagle Butte SD	PRIMARY	0.0

Question. As a part of the fiscal year 2002 Emergency Supplemental Appropriations bill, Congress provided an additional $417 million for VA medical care. Unfortunately, the President chose to veto $275 million of this funding.

What were the consequences in terms of care for our veterans of the President's decision not to spend this additional health care funding? Does your budget reflect these unmet fiscal year 2003 needs? Do you anticipate making a supplemental request for fiscal year 2003?

Answer. We do not anticipate a shortfall in fiscal year 2003. The demand for medical services in 2002 outpaced our capacity to provide timely, quality care to all who sought these services. As a result, we implemented policies to focus resources and care on our highest priority veterans—those with service connected conditions, low income and special needs veterans. To ensure that combat-disabled veterans can gain timely access to VA health care, the VA has published a regulation to provide for priority scheduling of appointments for veterans who are 50 percent or more disabled from service-connected causes and other veterans who are seeking care for their service-connected conditions. In the first quarter of fiscal year 2003, I made an enrollment decision to stop enrollment of most new Priority 8 higher income veterans for care starting on January 17, 2003 to continue the focus of care on our highest priority veterans.

Question. Ron Porzio, the Director of the Sioux Falls VA Medical Center, has been on administrative leave for several months. The acting director has done a fine job, but has no interest in a long-term administrative job. I am starting to hear from veterans who are concerned that the lack of a full-time, permanent director is starting to affect the operations at the Sioux Falls Medical Center.

When will this issue be resolved?

Answer. In September 2002, an administrative review was convened to investigate allegations made by one of Mr. Porzio's employees. The review team visited the Sioux Falls VAM&ROC and the findings of that investigation are not complete. We cannot speculate or comment on the outcome of the review while the case remains open and under review. Mr. Porzio remains on temporary detail at the VISN office in Minneapolis, MN.

On March 24, 2003, the Network Director appointed Rose Hayslett, an experienced Associate Director from Iowa City VAMC, as the Acting Director/Chief Operating Officer (COO) at the Sioux Falls VA Medical and Regional Officer Center (VAM&ROC). This appointment allows the Chief of Staff, serving as the Acting Director/COO, to fully concentrate on his clinical responsibilities. Ms. Hayslett was appointed Associate Director for Patient Care Services and Nurse Executive at the Iowa City VAMC in 1998. She served as Acting Medical Center Director for the Iowa City VAMC from September 2000 through January 2002.

QUESTIONS SUBMITTED BY SENATOR HARRY REID

Question. As you may know, I have recently re-introduced the Retired Pay Restoration Act (S. 392) seeking full concurrent receipt for our nation's veterans. Can you tell me the position of the Department of Veterans Affairs on this legislation?

Answer. S. 392 would amend 10 U.S.C. § 1414, to permit a former service member who is eligible for military retired pay under title 10 as well as disability compensation under Chapter 11 of title 38, U.S. Code, to receive both benefits without regard to 38 U.S.C. §§ 5304 and 5305. S. 392 would also repeal special compensation programs, codified in section 1413 and 1413a of Title 10, which provide monthly monetary benefits for certain severely disabled veterans and provide combat-related special compensation to military retirees.

Section 5304(a)(1) of Title 38 U.S. Code, prohibits, among other things, the award of VA disability compensation concurrently with military retirement pay, "[e]xcept to the extent that retirement pay is waived under other provisions of law." Such waiver is authorized by 38 U.S.C. § 5305, which permits a retired service member to waive part or all of his or her retirement pay to receive instead an equal amount of VA benefits. Waiver is often advantageous to the veteran because VA compensation, unlike military retirement pay, is not subject to income taxes. The amendments made by S. 392 would override section 5304 by expressly authorizing the concurrent payment of military retired pay and disability compensation for veterans.

New section 1414 would also establish a special rule regarding the payment of retired pay and disability compensation in the case of a former service member with 20 years or more of creditable service, who retires due to physical disability under Chapter 61 of title 10. Such a person's retired pay would remain subject to reduction under 38 U.S.C. §§ 5304 and 5305, but only to the extent that the individual's retired pay exceeds the amount of retired pay the individual would have been entitled to had they not retired under Chapter 61.

The Congress has considered numerous bills over the past few years to partially or completely repealed the prohibition against concurrent receipt. The 108th Congress so far has been presented with two bills that would allow full concurrent receipt for retirees with at least 20 years of service: H.R. 303 sponsored by Congressman Bilirakis, and S. 392 sponsored by Senator Reid. Both of these bills would remove the prohibition against concurrent receipt for all retirees with 20 plus years of service. However, any amount of disability retired pay that exceeds what the member would receive for longevity retirement remains subject to offset. In effect then, payments under H.R. 303 and S. 392 would work in much the same way as the recently enacted Combat-Related Special Compensation program, but without the requirement that the disabilities be combat-related. No added benefits would apply to those retired for disability with less than 20 years of service. But, full repeal of the existing prohibition is very expensive—our previous estimate is $58 billion over ten years ($42 billion associated with the additional cost of retired pay and the $16 billion associated with the payment of additional VA disability compensation for claims that would otherwise not be submitted). VA estimates that enactment would result in 700,000 original claims and 118,000 reopened claims over the next five years, increasing the existing backlog and adversely affecting timeliness. The Administration is on record as strongly opposing the changes included in these bills. Last year, the President's senior advisors recommended that he veto such legislation if it were presented to him.

Question. Although we were not able to pass full concurrent receipt last year, we were able to broaden the special compensation programs. Under the law passed last year, veterans with a 60–100 percent combat related disability and Purple Heart recipients will be able to draw retirement pay and receive disability benefits concurrently. There has been a great deal of confusion about how this program will be implemented. Will the Department of Veterans Affairs play any role in distributing these benefits or is the Department of Defense (DOD) taking the lead?

Answer. Department of Defense (DOD) will take the lead in administration of this program. VBA will continue to work closely with DOD to provide all necessary information required for effective implementation.

Question. Please provide us with the office and contact person within DOD or the VA that is handling this matter.

Answer. We defer to the Department of Defense regarding a DOD contact for this issue. The VA contact for this program is Thomas Pamperin, Assistant Director for Policy, Compensation and Pension Service.

Question. Please provide an update on your plan for the VA Clinic in Las Vegas. What obstacles, if any, have you encountered in your efforts to plan for and build a new facility? Have you settled on a location for the clinic? What is the time frame

for completion? In the interim period, what is your plan on how to treat the veterans living in the Las Vegas area?

Answer. Based on VA's need to find a permanent location for our major Ambulatory Care Center (ACC) in Las Vegas, a planning committee was tasked with evaluating VA long-term workload requirements in Southern Nevada and options for the future delivery of services. That committee produced a report that is pending final review and approval but that was shared with Nevada congressional offices in January 2003. The committee evaluated four options and recommended the following as the preferred long-term strategy: 1) to locate the replacement ACC and a Veterans Benefits Regional Office in a downtown Las Vegas location, and 2) to meet projected VA hospital bed needs (84 beds total) by expanding inpatient care at the Mike O'Callaghan Federal Hospital.

Based on an offer made by the City of Las Vegas, VA evaluated land in the former Union Pacific rail yard as a potential location for the replacement ACC. However, it has recently been determined that there is not sufficient available acreage that the City can make available at that location for the type of facility VA needs. VA is in need of a two- or three-story clinic on twenty to thirty acres of land, so that surface parking can be available. An advertisement soliciting land for the ACC was put in the local papers over the weekends of April 5/6 and April 12/13. VA's goal is for fast-track construction and to activate this clinic as soon as possible. It is not possible at this time to give a precise timetable for activation.

In the interim, VA is in the process of relocating its operations from the current Addeliar Guy ACC to 10 separate and new locations in the Las Vegas metropolitan area. The plan is to be completely out of the current ACC location by the end of May or early June 2003. To date, surgical clinics from the ACC have been relocated to the Mike O'Callaghan Federal Hospital. Information Technology and telecommunications operations have been moved and the warehouse operation has been partially relocated to a new site.

Prior to relocating any clinic operations to a new site, VA provides veterans with instructions and information regarding the new location and how their care will be provided. Contact points for appointment information and transportation information, including maps and directions, are included in this written instruction packet.

To date, the relocations that have occurred have been done with a minimum of disruption for either staff or patients.

Question. On numerous occasions when I have met with veterans from Northern Nevada they expressed concerns about the quality of care available in the Elko area. Do you foresee additional funding being directed to facilities in this region?

Answer. The CARES planning process in VISN 19 has identified several population centers that could benefit from greater accessibility to VA health care services. Elko, Nevada is one of those areas. The Elko area is in the catchment area of the VA Salt Lake City Health Care System. Salt Lake is proposing a new CBOC to be located in Elko, and they are currently working on a business plan and proposal.

Question. The Veterans Health Administration's facilities in Reno fall under the umbrella of the Sierra Pacific Network while facilities in northeastern Nevada are part of the Rocky Mountain Network. I believe it would benefit the Veterans Health Administration to incorporate Northeastern Nevada into the Sierra Pacific Network which is already dealing with the majority of cases from the northern region of my state, and is well versed in the needs of veterans from this area. Can you please comment on the feasibility of moving the boundary to incorporate Elko and surrounding areas into the Sierra Pacific Network?

Answer. The original network boundaries were determined by historical referral and patient origin patterns. More veterans in northeastern Nevada use the Salt Lake City VA Medical Center than the Reno VA Medical Center. Elko and surrounding areas are slightly closer to Salt Lake City than Reno. Salt Lake City also provides a greater range of health care services than Reno. Reno refers many veterans in need of highly specialized services to the San Francisco Bay Area VA Medical Centers. There is no compelling advantage to change the network boundaries. As noted in the response to the previous question, Salt Lake City is proposing a new CBOC to be located in Elko, and they are currently working on a business plan and proposal.

QUESTIONS SUBMITTED TO THE INSPECTOR GENERAL

QUESTIONS SUBMITTED BY SENATOR BARBARA A. MIKULSKI

PHYSICIAN TIME AND ATTENDANCE

Question. What did the IG find about physician time and attendance?

Answer. VA medical center managers did not ensure that part-time physicians met employment obligations required by their VA appointments. Although VHA had established time and attendance policy and procedures to account for part-time physicians, neither VHA headquarters officials nor VA medical center managers enforced the policy. VHA management at many levels told us they were generally satisfied with physician productivity and believed VA received more value than it paid for from the services provided by part-time physicians, despite apparent timekeeping violations. Results of audit clearly showed that part-time physicians were not working the hours established in their VA appointments and as a result part-time physicians were not meeting their employment obligations to VA.

VHA does not have effective procedures to align physician-staffing levels with workload requirements. VA medical centers did not perform any workload analysis to determine how many full time employee equivalents (FTE) were needed to accomplish the medical centers' workload or evaluate their hiring alternatives (such as part-time, full-time, intermittent, or fee basis). VA medical center managers responsible for staffing decisions did not fully consider the physicians' other responsibilities—such as medical research, teaching, and administration—when they determined how many physicians the VA medical centers needed. VHA officials told us the determination of the number of part-time physician FTEs needed has more to do with the financial needs of the affiliated university in meeting physician pay packages, than the number of hours needed by VA to meet patient workload requirements. In addition, only one of the managers at the five VA medical centers we visited, had informed their part-time physicians of what was expected of them to meet their VA employment responsibilities. We believe communication of expectations and responsibilities would significantly improve operations at the VA medical centers.

Question. How much VA funding is "lost" due to this problem?

Answer. The issue of lost VA funding is not just a consideration of paying physicians for time that was not directed towards VA duties. In considering the lost opportunity costs VA would need to evaluate the value of such issues as the costs of not providing care to veterans on waiting lists, the inability to bill for medical care that was provided by residents and not properly supervised by attending physicians, the value of any research conducted for which VA does not get credit as well as the salary paid for service that was not provided. While we did not quantify the value of the time that VA physicians did not spend at VA, at a minimum we noted, that about 11 percent of VA physicians were not meeting their employment obligations. In addition, from fiscal year 1997 through the second quarter of fiscal year 2002, the Federal Government paid, on behalf of VA, at least $21 million for 63 malpractice cases where VA's peer review panel found that the attending VA physicians provided substandard resident supervision. Based on our review of available documentation, the attending physicians were not present to supervise the residents during the performance of a procedure or the provision of a treatment to a veteran in at least eight cases resulting in malpractice settlements totaling $4.7 million. An additional pending case involves an attending surgeon who could not provide needed assistance to a VA medical center patient because he was operating on a non-veteran patient at the affiliated medical school.

Question. Do you think this is a matter of fraud by VA doctors, or is it because of VA's lack of standards?

Answer. There are cases where fraud is a possibility. In addition, some VHA managers were not willing to enforce existing time and attendance controls, and VHA does not have effective procedures to align physician-staffing levels with workload requirements.

Further, inherent conflicts of interest that exist for the part-time physician with a dual appointment with the affiliated medical school contributed to the weak internal controls. Most VA supervisors of part-time physicians were also faculty members at the same university medical school as their subordinates. At one VA medical center, the service chiefs told us they did not consider themselves to be supervisors with any direct authority over their subordinate physicians—rather they were colleagues and served in a liaison role between VA medical center management and the physicians. From our discussions with managers and physicians at five VA medical centers and VA's Central Office, universities generally pay their physicians a

base salary plus additional compensation based on the number of procedures or the level of productivity they achieved in their clinical practices. This compensation package provides a strong incentive for physicians to maximize the time they spend at the university medical schools. When the physician's supervisor has the same incentive based compensation package—as is apparently the case at affiliated VA medical centers—the integrity of the supervisory role is compromised. (IG)

Question. The VA's budget proposes to hire 3,800 new doctors and nurses to address the waiting lists. How can VA ensure that new and existing doctors know what is expected of them?

Answer. Require that Veterans Integrated Services Network (VISN) and medical center directors ensure part-time physicians meet their employment obligations and hold field managers accountable for compliance. (IG)

—Determine what reforms are needed to ensure VA physician timekeeping practices are effective in an academic medicine environment and VA physicians are paid only for time and service actually provided. Recommend statutory or regulatory changes needed to implement the reforms and publish appropriate policy and guidance.

—Establish performance monitors to measure VISN and medical center enforcement of physician time and attendance; ensure desk audits are conducted of timekeeping functions; provide continuing timekeeping education to supervisors, physicians, and timekeepers; require medical center managers to certify compliance with applicable policies and procedures to VHA's Deputy Under Secretary for Operations and Management annually; and hold VHA managers accountable for successful implementation of time and attendance requirements.

—Apprise all part-time physicians of their responsibilities regarding VA timekeeping requirements.

—Evaluate appropriate technological solutions that will facilitate physician timekeeping.

—Develop comprehensive guidance for medical centers to use when conducting desk audits.

—Establish appropriate training modules, making the best use of technological solutions for training VHA managers, VA physicians, and timekeepers in timekeeping requirements, responsibilities, and procedures.

—Publish policy and guidance that incorporates the use of workload analysis to determine the number of physicians needed to provide timely, cost effective, and quality service to veterans seeking care from VA.

—Require medical centers to review their staffing structures (such as part-time, full-time, intermittent, or fee basis) and determine if these appointments are appropriate to the needs of the medical center.

—Require that VISN and medical center directors reassess staffing requirements annually and certify their staffing decisions to VHA's Deputy Under Secretary for Operations and Management.

—Evaluate alternative methods to acquire physician services and publish national guidance to assist VISN and medical center directors in determining the best strategies for their regional, academic, and patient care circumstances.

—Publish guidance describing how VISN and medical center managers should determine, monitor, and communicate the allocation of physician time among patient care, administrative duties, academic training, and medical research.

MEDICAL RESEARCH

Question. Does VA have adequate controls to enforce patient safety in medical research?

Answer. Currently, the Office of the Inspector General has an ongoing criminal investigation involving one facility's medical research program. The OIG cannot comment on a criminal investigation in progress. The OIG does not have any other work underway, or recent reviews, that could be a body of knowledge on the effectiveness of VA controls for patient safety in medical research.

The Program on Research Integrity Development and Education (PRIDE), within the Office of Research and Development (ORD), is responsible for providing education and policy on protection of human participants in VA research.

Please refer to VA's responses to questions on "Patient Safety in Medical Research" that provide information on VA safeguards for patients who participate in VA research studies, VA procedures to inform patients fully of the risks of research, and VA's safety standards for research involving patients.

SUBCOMMITTEE RECESS

Senator BOND. A great honor, appreciated you being there. Thank you very much.

The hearing is recessed.

[Whereupon, at 11:40 a.m., Thursday, March 13, the subcommittee was recessed, to reconvene subject to the call of the Chair.]